MENTAL HEALTH SERVICE USERS AS PEER PROVIDERS IN HAWAIʻI: UNDERSTANDING RECOVERY PATHS AND PERSPECTIVES

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ABSTRACT

The purpose of this study was to examine the lived experiences of Hawaii's mental health service users in becoming certified peer providers. Qualitative methods were used to understand the perspectives of eight (8) mental health service users trained and credentialed through the Hawaii Certified Peer Specialist (HCPS) program. Data were analyzed at two levels. At the first level, an inductive approach using grounded theory identified four themes across participants: (1) prior to training and certification, the prospect of participation instilled hope of moving forward in their own recovery and helping others with similar lived experiences; (2) subsequent to training and certification, the lack of follow-up support services and few employment opportunities resulted in feelings of frustration and hopelessness; (3) ongoing systemic stigma and discrimination maintain barriers to integration; and (4) completion of the program increased their confidence, decreased their feelings of isolation, increased their empathy towards others with mental illness, and broadened their perspectives and worldviews. At the second level, themes from the first-level analysis were examined through the lens of Critical Disability Theory. Together, the first and second-level analysis provide unique insights into potential motivation factors for Hawaii's mental health service users applying to the HCPS program. Findings also highlight organizational barriers that hinder the integration of peer providers as employees in traditional mental health service settings. Implications for policy, social work practice, and future research are discussed.

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CHAPTER 1: INTRODUCTION

In 2002, President George W. Bush charged a group of 15 commissioners to conduct a study to determine the problems and gaps in America's mental health service delivery system. The Commission's final report outlined six goals and 19 recommendations (see Appendix A for the President's New Freedom Commission's Goals and Recommendations) as the foundation for transforming mental health care in America. Successful transformation, according to the Commission, rests on two principles: first, mental health services and treatments are consumer and family-centered. Second, mental health services must focus on facilitating recovery (President's New Freedom Commission, 2003).

Goal two of the President's New Freedom Commission, *Mental Health Care is Consumer and Family Driven*, includes a recommendation that emphasizes the need for systems to actively involve mental health service users and their families in planning, delivering, and evaluating mental health and treatment support services. The Commission also emphasized the need for increasing opportunities for mental health service users to share their knowledge, skills, lived experiences, and lived expertise in recovery. The President's New Freedom Commission (2003) explained, "Recovery-oriented services and supports are often successfully provided by [mental health] consumers… who work as providers in a variety of settings" (p. 45). The report formally acknowledged the unique and valuable contributions that peer providers have on facilitating recovery among adults with serious mental illness (President's New Freedom Commission, 2003).

Peer specialists, also referred to as peer providers, are mental health service users with lived expertise and histories of living with a serious mental illness (SMI) who provide direct services and supports to others with similar conditions (Daniels, Bergeson, Fricks, Ashenden &

Powell, 2012; Solomon, 2004). The employment of peer specialists is a recent advancement in community mental health. Over the last thirty years, there has been a rapid proliferation of training, credentialing, and employing peer specialists to work in traditional mental health service settings (i.e., inpatient and community-based outpatient programs that assess, diagnose, and treat individuals with mental disorders; Davidson, Chinman, Sells, & Rowe, 2006). The impetus for this change is largely attributed to the advancement of recovery as an overarching philosophy of care in behavioral health (United States Department of Health & Human Services, 1999), various reports and position statements prepared by state and federal entities endorsing the use of peer support services (e.g., President's New Freedom Commission, 2003), and a growing body of evidence that peer support services decrease inpatient service use (Clarke et al., 2000; Landers & Zhou, 2011; Sledge, Lawless, Sells, Wieland, O'Connell, & Davidson, 2011), increase service engagement and participation in outpatient mental health treatment (Craig, Doherty, Jamieson-Craig, Boocock, & Attafua, 2004a; Felton et al., 1995; Sells, Davidson, Jewell, Falzer & Rowe, 2006), and improve the overall quality of life of mental health service users (Felton et al., 1995; Repper & Carter, 2011). In addition, the ability for public-sector mental health service systems to fund paid peer positions, primarily through Medicaid, has greatly supported the expansion of peer support services and peer specialists across the behavioral health continuum of care (Davidson et al., 2006).

In 2007, the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) issued a letter to all State Medicaid Directors identifying peer support services as an evidence-based practice (CMS, 2007). The letter provided guidance to states on establishing peer support services as a covered benefit under the Medicaid program. State Medicaid agencies that choose to include peer support services as a Medicaid reimbursable

service activity are expected to establish standards for training, credentialing, continuing education, and supervision for peer specialists (CMS, 2007). As of 2017, 42 states, including Hawaii, have amended their Medicaid State plans to include peer support as a covered health benefit (Kaufman, Brooks, Steinley-Bumgarner & Stevens-Manser, 2014; Kaufman, Kuhn, & Stevens-Manser, 2017). Forty-one states, including Hawaii, have established state-approved training and credentialing programs to certify individuals with lived histories of mental disorders as peer specialists (Kaufman et al., 2017). It is estimated that more than 13,000 individuals across the nation have been trained and certified as peer specialists (Chapman, Blash, & Chan, 2015).

In their review of peer specialist training and certification programs across the nation, Kaufman et al. (2017) highlights major differences between existing programs (e.g., certification requirements, training criteria, employment opportunities). Although not stated, these differences may account for why mental health service users choose to become peer providers. At present, little is known about why Hawaii's mental health service users choose to participate in Hawaii's peer specialist program and what happens to mental health service users after they complete the peer specialist training.

Purpose of the Study

To date, no study has examined why mental health service users in Hawaii choose to become peer specialists. Further, no study has examined the recovery experiences and perspectives of Hawaii's mental health service users after they become certified as Hawaii Certified Peer Specialists. In addition, no study has examined Hawaii's mental health service users' perspectives and experiences of the program itself, and how these perspectives and experiences influence, affect, or impact their recovery.

The purpose of this study was to examine the experiences and perspectives of Hawaii's mental health service users in becoming peer specialists and what their perspectives and experiences can possibly tell us about their recovery. Utilizing a qualitative methodology to gain in-depth understanding of Hawaii's peer providers' experiences, the following three research questions served as a guide for this study:

1. Why do Hawaii's mental health service users choose to become peer specialists?
2. What are Hawaii's peer providers' experiences following certification?
3. How did the Hawaii Certified Peer Specialist (HCPS) program impact their recovery?

Positionality: Introduction to the Researcher

Charmaz, Thornberg, and Keane (2017) highlight, "Our autobiographies and the meanings we hold of historical events heavily influence our standpoints, positions, and perspectives and inform our starting positions as researchers and thus our completed analyses" (p. 426). Addressing positionality acknowledges my history, social standing, and cultural background that I bring to this study (Charmaz et al., 2017). As a white, heterosexual, non-disabled, licensed clinical social worker and certified substance abuse counselor, I recognize and am sensitive to the "differential and unequal position of power and privilege" I assume conducting this inquiry (Charmaz et al., 2017, p. 427). Further, my experiences as a family member and friend to loved ones in recovery from a SMI provides me with unique insights and perspectives as well as potential biases.

My introduction to the concept of recovery and to peer specialists began in 2003 when I completed my first internship at an outpatient mental health clinic. During this time, I co-facilitated groups with a HCPS. The HCPS who worked with me was a member of the first graduating class of HCPSs. Since then, I have worked with peer specialists in various positions

and in different roles. In my previous position with the Hawaii State Department of Health, I supported different administrators and staff assigned to the HCPS program. Since 2014, I have been employed by a large managed care organization (MCO) that employs peer specialists across the nation. In my current role, I am tasked with promoting recovery across the MCO's local network of providers and internally within various departments and teams.

Throughout my professional tenure as a social worker, peer specialists in Hawaii and across the nation have shared aspects of their recovery stories and described both positive and negative aspects of becoming a peer provider and their experiences working in traditional mental health service settings. This study represents an opportunity and privilege to share some of their stories and to give voice to their perspectives and recovery experiences.

CHAPTER 2: LITERATURE REVIEW

This chapter outlines the historical context and evolution of peer support in traditional mental health service settings. It begins with a brief overview of SMI, including various social problems associated with SMI, an introduction to the recovery paradigm, a brief history of the mental health consumer/psychiatric survivor movement, recovery-related outcomes for mental health service users receiving peer support from peer specialists, benefits to mental health service users who are peer providers, benefits to mental health services providers that employ peer providers, and the experiences of peer providers as paid employees in traditional mental health service settings. It ends with an overview of barriers towards employing peer providers in traditional mental health service settings. Key terms for this study have been identified in Appendix B.

Serious Mental Illness

In 2013, an estimated 4.2% of the American adult population (9.8 million people) had a SMI (Substance Abuse & Mental Health Services Administration [SAMHSA], 2015). In the same year, 23.1% of adults with a SMI also met criteria for a substance use disorder (SAMHSA, 2014). SMI is a major public health concern (US Department of Health and Human Services, 1999), both in its own right and because of the high incidence of chronic, co-morbid medical conditions that lead to increased morbidity and mortality (National Association of State Mental Health Program Directors [NASMHPD], 2006). Adults with SMI also experience disproportionate rates of unemployment (Cook, 2006; Luciano & Meara, 2014), homelessness (Greenwood & Rosenheck, 2010), and involvement in the criminal justice system (Baillargeon, Hoge & Penn, 2010; Ditton, 1999).

Morbidity and mortality. Adults with SMI have morbidity and mortality rates higher than those found in the general population (Demblin, Chen, & Vachon, 1999; Jones, Macias, Barreira, Fisher, Hargreaves, & Harding, 2004) and die, on average, 25 years younger than others without SMI (NASMHPD, 2006). More than half of all premature deaths are due to the high prevalence of chronic, co-morbid medical conditions, such as cardiovascular and pulmonary diseases (NASMHPD, 2006). Among adults with SMI, those who have co-occurring substance use disorders (COD) are at greater risk and die, on average, 32 years younger than others in the general population (Miller & Prewitt, 2012).

Unemployment. In a nationally representative sample of working-age adults between the ages of 18 and 64 in 2009, adults with SMI were less likely to be employed than others without mental disorders (Luciano & Meara, 2014). In Luciano and Meara's (2014) study, 38% of adults with SMI worked full-time compared to 61.7% of adults without a mental disorder. Further, Luciano and Meara (2014) found statistically significant differences when comparing employment rates across mental illness severity groups. Other studies examining employment among adults with SMI found similar results. In Smith & Bhattarai (2008) study, only 22% of all adults receiving behavioral health services in community mental health programs were competitively employed.

Homelessness. The Department of Housing and Urban Development (HUD; 2017) estimated that 553,742 individuals across the United States were homeless on any given night in January of 2014. Of those who were identified as homeless, approximately 111,902 people or 20% had a SMI (HUD, 2017).

Involvement in the criminal justice system. Estimated rates of SMI among incarcerated populations are consistently higher than the general population (Davis, Fulginiti, Kriegel, &

Brekke; 2012; Osher, D'Amora, Plotkin, Jarrett, & Eggleston, 2012). While estimates vary across studies (Baillargeon et al., 2012), the available literature suggests that 16 to 25% of those incarcerated in prisons and jails have a SMI (Ditton, 1999; National Commission on Correctional Health Care, 2002). The prevalence of adults with SMI entering jails is estimated at 17% (14.5% of men and 31% of women), a rate three times higher than in the general population (Steadman, Osher, Robbins, Case & Samuels, 2009). Among adult males on correctional supervised release, approximately 8% of probationers and 7% of parolees have a SMI (Feucht & Gfroerer, 2011).

Mental Health Treatment Service Utilization Among Adults with SMI

According to SAMHSA (2014, 2015), mental health treatment service utilization rates among adults with SMI are low - 36.4% of adult men and 28.4% of adult women did not receive counseling or mental health treatment in 2013. In other studies, more than half (54.8%) of adults with SMI did not receive mental health treatment (Kessler et al., 2001). Among adults with SMI receiving mental health treatment, few receive minimally adequate care (Wang, Demler, & Kessler, 2002). For example, Wang et al. (2002) estimates that only 1 in 20 adults diagnosed with nonaffective psychotic disorders receive quality mental health services.

Unmet need and inadequacy of mental health treatment services, according to Hogan (2002), diverts resources and results in costly tertiary health care interventions. Hogan (2002) argues, "the consequences for [mental health] consumers are worse than the costs for taxpayers" (p. 1252). Insel (2008) highlights that mental disorders, unlike other medical disorders, are not adequately captured in any analysis of health care costs. Indirect costs of untreated SMI result from a variety of factors, including high rates of emergency room care to treat complications associated with chronic, comorbid medical conditions and loss of productivity due to premature death, homelessness, incarceration, and unemployment (Insel, 2008).

Evolution from a Disease-Centric Medical Model towards a Recovery Paradigm

Throughout history, different models of mental distress have often prevailed, shaping the etiological perspectives and treatment modalities for people with mental disorders (Helmchen, 2013; Wyatt & Livson, 1994). Presently, an integrative model that incorporates biological, psychological, and social origins (i.e., the biopsychosocial model; Engel, 1977) of mental disorders is taught across health disciplines in behavioral health (e.g., psychology, nursing, social work; Ghaemi, 2003). The biopsychosocial model, according to Engel (1977), asserts that all three levels – biological, psychological, and social factors – are equally relevant at all times with all cases when considering the etiology and treatment of mental disorders. Yet, neuroscientific and biological conceptions of mental illness (i.e., medical model) continue to dominate the literature, research, terminology, nomenclature, and clinical practice for assessing, diagnosing, and treating mental disorders (Adame & Knudson, 2007).

The medical model conceptualizes psychiatric disorders as diagnosable health conditions characterized by alterations in thinking, mood, or behaviors that cause clinically significant distress, disability, or impairment of functioning in major life activities (Ritter & Lampkin, 2012; Wurtzberg & Rocchio, 2013). The model conceptualizes maladaptive psychological, emotional, and interpersonal experiences to neurobiological and physical deficits or dysfunction (Shah & Mountain, 2007; Wyatt & Levson, 1994). Proponents of the medical model use diagnostic nomenclature consisting of taxonomies of signs and symptoms to establish criteria for labeling a phenomenon a medical disease or disorder (Gerard, 1999). Similar to other disease conceptions, the model attributes different prognoses for each disorder and endorses specific medical interventions. Etiological theories based on biology place primary emphasis on biochemical and physical modalities to effectively treat various mental disorders; psychotherapy and other

psychosocial interventions are viewed as secondary or adjunctive to psychotropic medications and other medical treatments (Wyatt & Levson, 1994). In behavioral health, psychiatry maintains its power and allied health professions are subordinate to physicians. The emphasis of treatment is on objective, measurable outcomes specific to symptom reduction or remission, long-term maintenance or stabilization, and cure (Adame & Knudson, 2007).

The medical model has been criticized for being mechanistic, inhumane, and reductionistic (Shah & Mountain, 2007). Chamberlin (1977; 1990) and Deegan (1997), two leaders in the mental health consumer and psychiatric survivor movement, assert that reliance on the medical model have profound, negative effects for those labeled or diagnosed with a SMI. The medical model suggests that serious mental illnesses, especially schizophrenia spectrum and other psychotic disorders, are chronic, debilitating, and degenerative diseases with poor prognoses (Carpenter, 2002; Rapp & Gosha, 2011). This view, which emphasizes impairments, deficits, and chronicity, has dominated behavioral health professionals' attitudes towards SMI until fairly recently (Frese, Knight, & Saks, 2009).

Recovery from SMI. A series of longitudinal studies involving thousands of persons diagnosed with schizophrenia revealed heterogeneity in life experiences and positive quality of life outcomes across subjects (Harding, 2005; Jobe & Harrow, 2005; Warner, 2004; Wexler, Davidson, Styron, & Straus, 2007). Across these studies, subjects experienced significant or complete remission of symptoms, while others demonstrated significant improvements in social and psychological functioning (Kruger, 2000). These studies suggest that recovery from SMI is possible, and in fact, should be the expectation when mental health service users and those who choose not to use mental health service users are provided the right resources, services, and supports (Wexler et al., 2007).

The concept of recovery was first used by hospital superintendents of state psychiatric institutions to describe the absence of observed symptoms and signs for patients admitted to and discharged from these facilities (Adame & Knudson, 2007). The notion of recovery evolved beyond the medical model's narrow definition of symptom reduction, internal dysfunctions, and deficiencies to a deeply personal, self-defined, self-directed, holistic, and multifaceted process that enables adults with SMI to live, learn, work, recreate, and participate in communities of their choice (Cameron & McGowan, 2013; Carpenter, 2002; Onken, Craig, Ridgway, Ralph, & Cook, 2007). Recovery is often described as process where adults with SMI regain a positive sense of self (Schon, 2010) and develop new meaning beyond an illness-dominated identity (Mancini, Hardiman, & Lawson, 2005; Mead, Hilton, & Curtis, 2001). There is no single agreed-upon definition of recovery, nor single way to measure it (United States Department of Health and Human Services, 1999); however, SAMHSA (2012) offers a working definition of recovery that emphasizes recovery as a "process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (p. 3).

The emphasis of recovery as the prevailing service philosophy across behavioral health has contributed to growing acceptance of peer support across the continuum of care and to the utilization of peer providers in traditional mental health service settings (Salzer et al., 2002). Although the medical model remains the master narrative in research and in service delivery (Adame & Knudson, 2007), the adoption of recovery signifies a shift in the expectation towards positive outcomes for adults with SMI. The evolution of the recovery paradigm and assertion that peer support is instrumental to a person's recovery (SAMHSA, 2012) is largely attributed to the mental health consumer/psychiatric survivor's antipathy to the medical model (Frese & Myrick, 2010).

History of the Mental Health Consumer/Psychiatric Survivor Movement

The modern American mental health consumer/psychiatric survivor movement emerged in the late 1960s following large-scale deinstitutionalization of patients from state psychiatric hospitals to the community and into other settings (Reaume, 2002; Tomes, 2006). Former patients across the country gathered in small groups and realized that they, "like members of other marginalized groups, had been legally denied basic [human and civil] rights" (Frese & Davis, 1997, p. 244). First-person accounts shared among ex-patients highlighted distinct and systemic patterns of oppression, stigma, and discrimination in hospitals and in community settings (Chamberlin, 1990). Inspired by other civil rights movements at the time, former patients organized into what was then referred to as the Mental Patients Liberation Movement (United States Department of Health and Human Services, 1999), later renamed as the Mental Health Consumer/Psychiatric Survivor Movement (Van Tosh & DelVecchio, 2000).

The Mental Health Consumer/Psychiatric Survivor movement originally consisted of loosely organized autonomous groups that primarily focused on social justice through advocacy and self-help alternatives to traditional mental health treatment that was provided by mental health professionals (Chamberlin, 1990; Ruter & Swarbrick, 2010). Activists publicly disclosed and published first-person accounts of their personal histories and experiences in psychiatric institutions (Reaume, 2002), as well as asserting their perceptions and opinions regarding psychiatric conditions and the mental health system itself (Frese, Knights & Saks, 2009). Advocates argued that former patients had a right to exercise their freedom and a right to self-determination, as well as access to non-professional, non-coercive, voluntary, and self-directed services (Chamberlin, 1978, 1984; Zinman, 1982).

The Insane Liberation Front, considered the first known group of the modern consumer/psychiatric survivor movement (Tomes, 2006), organized in Portland, Oregon in 1970 (Reaume, 2002). Other groups across the country soon followed, including the Mental Patients' Liberation Front, Mental Patients' Liberation Project, and Network Against Psychiatric Assault (Frese & Myrick, 2010; Zinman Budd, & Bluebird, 2009). Activists intentionally chose words to challenge discriminatory stereotypes that renounced their role as powerless victims, while using language that conveyed a sense of liberation against oppressors from medical and psychiatric establishments (Frese & Davis, 1997; Reaume, 2002). Former patients referred to themselves as 'inmates,' suggesting that hospitals were prisons, and 'survivors' to emphasize the widespread abuse and iatrogenic trauma patients endured at these institutions (Chamberlin, 1990). Early pioneers also aligned themselves with the intellectual traditions of the antipsychiatry movement (Frese & Myrick, 2010), describing madness as an alternative state of being in their speeches and writing (Tomes, 2006). Over time, other groups organized and represented more moderate viewpoints.

Activists demanded to be involved in various forums (e.g., legislative hearings, conferences, boards) from which they had been excluded in the past (Chamberlin, 1984, 1990). For example, activists attended President Jimmy Carter's Commission on Mental Health's public hearings giving testimony on harmful psychiatric treatments, patient rights, and the need to fund alternatives to traditional mental health treatment (Chamberlin, 1990; Frese & Davis, 1997; Grob, 2005). In the final report to President Carter, the Commission officially acknowledged the movement and proliferation of mutual-help groups for mental health consumers and survivors (President's Commission on Mental Health, 1978).

Greater receptivity to mental health service user involvement became evident when Congress passed the State Comprehensive Mental Health Service Plan Act of 1986 requiring states to include mental health service users on their state mental health planning councils. Inclusion of mental health service users ensured advocates were involved in all aspects of the planning, delivery, and evaluation of publicly funded mental health services. Advocates were also able to ensure that services that support self-determination and recovery were integrated throughout the system's continuum of care (Van Tosh & del Vecchio, 2000).

The establishment of an office of consumer affairs within state mental health authorities represents another significant development in the movement. In 1990, Alabama (Alabama Department of Mental Health, n.d.) and New Hampshire (New Hampshire Department of Health and Human Services, 2010) were the first two states to have established an office of consumer affairs. In 2008, 30 states had an Office of Consumer Affairs within their state's mental health authority that were staffed by former and current mental health service users (Corrigan, Mueser, Bond, Drake, & Solomon, 2008). The mental health consumer/psychiatric survivor movement was instrumental in shaping legislation and policy to promote the philosophy of recovery and the use of peer delivered services and integration of peer specialists into traditional mental health service settings.

Peer Providers in Traditional Mental Health Service Settings

The introduction and use of peer providers in traditional mental health service settings arose in the 1990s as mental health systems began to endorse and promote the recovery model as an overarching philosophy of care (Davidson et al., 2006; Wexler et al., 2007). Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD), in partnership with Georgia's Mental Health Consumer Network, developed the nation's first peer specialist

program (Sabin & Daniels, 2003). The DBHDD's Office of Consumer Relations and the Georgia Mental Health Consumer Network developed their peer specialist training and certification program to teach and foster development of core competencies necessary for carrying out responsibilities outlined in the State's Certified Peer Specialist job description (Hoge et al., 2005). In December 2001, 35 mental health service users passed an oral and written examination to become the first graduating class of state-certified peer specialists (Georgia Certified Peer Specialist Project, 2003; Salzer, Schwenk, & Brusilovskiy, 2010). In 2003, Georgia became the first state to include peer support services as a Medicaid billing option (Sabin & Daniels, 2003).

Hawaii. In 2003, Fricks and Powell, two nationally recognized peer specialists from Georgia, trained the first cohort of mental health service users in Hawaii to become certified peer specialists. The curriculum used to train mental health service users in Hawaii was originally developed for Georgia's certified peer specialist program. The two trainers partnered with peer leaders in Hawaii and enhanced the curriculum to ensure its relevance and applicability to mental health service users in Hawaii. Thirty-six mental health service users participated in the 2003 training. Thirteen individuals who participated in this training took the required oral and written examination, and eight passed both examinations to become the first cohort of HCPSs. Thirteen additional individuals from the first training in 2003, who had either failed or had not taken the examination, were later credentialed in 2004. Two years following the first training, two certified HCPSs employed by the State of Hawaii were trained to train future cohorts of mental health service users to become certified peer specialists (Hawaii State Department of Health, Adult Mental Health Division, 2014).

According to Kaufman et al. (2017), 190 individuals have been trained and certified in Hawaii as peer specialists. At present, there are no publicly available reports from the State of

Hawaii that provide data on the number of mental health service users who have applied to the program, number of applicants who were accepted into the program, number of applicants who completed the program, demographic characteristics or applicants and HCPSs, and number of HCPSs who became actively employed as a peer specialist in community mental health service settings. In addition, the number of HCPSs who have maintained their certification in accordance to standards set forth in Hawaii's Medicaid State Plan (CMS, 2013) and by the Department of Health is not known or made publicly available.

The establishment of the HCPS training and certification program was in response to requirements outlined in the settlement agreement (consent decree) between the U.S. Department of Justice and the State of Hawaii (Hawaii State Department of Health, Adult Mental Health Division, 2003). In 1991, two years following its on-site evaluation of the Hawaii State Hospital, Hawaii's only state-run and operated psychiatric hospital, the U.S. Department of Justice filed a lawsuit under the Civil Rights of Institutionalized Persons Act of 1980 (CRIPA) against the State of Hawaii for depriving the constitutional rights and privileges of patients (Gochros, 1994; Sagar, 2008). The CRIPA grants authority to the Department of Justice to conduct on-site evaluations to ensure the constitutional rights of residents in state (public) institutions are maintained while they are in confinement (Davis, 2008). In addition, the CRIPA provides a legal foundation for federal intervention and penalties when states fail to honor recommended changes made by the Department of Justice. The lawsuit against the State of Hawaii was expanded to include the development and implementation of a comprehensive community mental health services plan outside the state hospital, including the establishment of an Office of Consumer Affairs within the State Mental Health Authority and the creation of a certified peer specialist program (Davis, 2008; Hanson-Mayer, 2006).

In 2013, the State of Hawaii's Department of Human Services Med-QUEST Division (the Single State Medicaid Agency) officially designated the Hawaii State Department of Health's Adult Mental Health Division (Hawaii's State Mental Health Authority) to assume responsibility for credentialing peer specialists (CMS, 2013). The HCPS Program, operated by the Adult Mental Health Division's Office of Consumer Affairs (OCA), manages all aspects of selecting, training, credentialing, and re-credentialing individuals that have self-identified as having a mental disorder or co-occurring mental and substance use disorder to become a HCPS.

HCPS certification is only awarded to candidates who have (1) attended the AMHD OCA-approved HCPS Training, (2) successfully passed both oral and written examinations that demonstrate mastery in core competencies of peer-to-peer support, and (3) completed the 3-month required paid internship with an AMHD funded or other approved behavioral health provider. The AMHD OCA requires HCPS's to complete, at minimum, 16 hours of continuing education annually to maintain their certification (Hawaii State Department of Health, 2012).

Hawaii Certified Peer Specialist application process. The OCA requires all applicants to (1) be 18 years of age and older, (2) have a high school degree or general equivalency degree, (3) have a primary diagnosis of a mental disorder or co-occurring mental and substance use disorder, (4) self-identify as a mental heath consumer or person who has received mental health treatment, and (5) have demonstrated at least 12 consecutive months of self-directive recovery within 2 years of submitting their application. Self-directive recovery, as defined by OCA, is described as being involved in leadership, advocacy, and peer support (Hawaii State Department of Health, Adult Mental Health Division, 2012).

Applicants must submit the HCPS application packet available online to the OCA. The packet includes an application form, professional reference form, and three attestation forms.

The application form asks candidates for their contact information and to answer four closed (i.e., yes/no) and two open-ended questions. The four closed questions ask applicants: (1) whether they are comfortable and willing to self-disclose and share their lived experiences and recovery from a mental illness with others, (2) whether they have demonstrated a minimum of 12 consecutive months in self-directed recovery, (3) whether they have attended community-based peer-led trainings, and (4) whether they had previously participated in the HCPS program. The two open-ended questions ask candidates to (1) describe what motivates and qualifies them to become a HCPS, and (2) describe how they take care of themselves and their recovery. Applicants are required to submit three professional references. Professional references are asked to (1) describe the nature of their professional relationship with the applicant, (2) describe their knowledge of the applicant's capacity and experience providing peer support in mental health service settings, and (3) describe the applicant's strengths and weaknesses regarding their ability to provide peer support as a HCPS. The three attestation forms instruct applicants to review, sign, and submit a form acknowledging their (1) understanding and agreement to honor the HCPS Code of Ethics; (2) understanding of the HCPS role, responsibilities, and scope of activities; and (3) intention to complete the HCPS training, complete the paid internship, and become gainfully employed as a HCPS in Hawaii (Hawaii State Department of Health, Adult Mental Health Division, 2012).

At the time this literature review was completed, information regarding processes for selecting candidates for the HCPS training was not publicly available or described.

HCPS training and curriculum. The HCPS training is a two-week, 80-hour training with a mandatory 3-month paid internship (Hawaii State Department of Health, Adult Mental Health Division, 2012). The HCPS training has consistently used Georgia's certified peer specialist core

curriculum. The curriculum is proprietary and is taught by local HCPSs who have received training by the Appalachian Consulting Group to be trainers or have been designated as trainers by the State Mental Health Authority (Hawaii State Department of Health, Adult Mental Health Division, 2014).

The core curriculum is organized into 25 sections with each section having multiple parts. Trained facilitators use various teaching methods, including didactic lectures, modeling, role-playing, and small group discussions to facilitate learning. The training begins by introducing participants to the recovery model and role of peer support in facilitating and helping others. Participants reflect on their own life experiences and learn to use their own story of recovery as a tool to inspire and support others. Participants are also guided through different activities to identify programmatic and relational attributes within behavioral health settings that promote and support recovery (Appalachian Consulting Group, 2006a; 2006b).

Participants are oriented to the curriculum's five stages of recovery. Facilitators guide the class with identifying stage-specific supports, including strategies for overcoming negative self-talk, addressing fears, and helping peers identify and clearly articulate barriers preventing them from accomplishing their goals. Participants are also introduced to effective listening skills, conflict resolution, goal setting, and problem solving techniques. They are provided an overview of evidence-based practices in mental health, the state mental health service system, and differences between mental health treatment and mental health rehabilitative services. Throughout the years, the trainings have evolved to incorporate other topics, including Wellness Recovery Action Planning and Seeking Safety (Hawaii State Department of Health, Adult Mental Health Division, 2007).

Unique Roles of Peer Providers in Traditional Mental Health Service Settings

Davidson, Bellamy, Guy, & Miller (2012) highlight two contributions that distinguish peer providers from non-peer providers in traditional mental health service settings. First, peer providers instill hope in mental health service users through positive use of self-disclosure and role modeling. Second, peer providers present novel approaches based on experiential knowledge (specialized information and perspectives that people obtain through their own lived experiences; Solomon, 2004) that have helped them and others manage their illness and better negotiate psychosocial and socioeconomic problems associated with SMI (e.g., housing instability, stigma, poverty; Davidson et al., 2012). Other contributions identified by peer providers as unique to their profession include interventions that focus on promoting health and wellness, addressing hopelessness, improving communication with traditional mental health service providers, educating peers on illness management, and combating stigma (Salzer et al, 2010).

The unique nature of relationship between peer providers and mental health service users is believed to contribute to a peer specialists' ability to better engage adults with SMI that are alienated from or reluctant to participate in the behavioral health system (Craig et al., 2004a; Davidson et al., 2006, 2012; Felton et al., 1995; Sells et al., 2006; Solomon, Draine, & Delaney, 1995). Despite these promising findings, none of these studies include peer specialists from Hawaii.

Effectiveness of Peer Providers

In this section, the effectiveness and benefits of peer providers in dedicated peer roles in traditional mental health service settings are discussed. This review does not include studies that examined outcomes or experiences of peer providers functioning in traditional mental health service roles (e.g., case managers, psychologists; see Chinman, Rosenheck, Lam, & Davidson,

2000; Sells et al., 2006; Solomon & Draine, 1995; Solomon et al., 1995) or peer providers delivering structured curricula. In addition, studies that examined outcomes of informal peer support, peer-run (i.e., mental health consumer-operated) programs, or peer recovery support specialists - individuals in recovery from substance use disorders providing peer support to others with substance use disorders (Reif et al., 2014) - were not considered.

Outcomes for mental health service users who receive peer support services. Results from a recent literature review conducted by Chinman et al. (2014) identified five randomized controlled trials (Craig et al., 2004a; Davidson, Shahar, Stayner, Chinman, Rakfeldt, & Kraemer Tebes, 2004; O'Donnell et al., 1999; Rivera, Sullivan, & Valenti, 2007; Sledge et al., 2011), three quasi-experimental studies (Felton et al., 1995; Schmidt, Gill, Wison Pratt, & Solomon, 2008; Van Vught, Kroon, Delespaul & Mulder, 2012), and one correlational study (Landers & Zhou, 2011) that examined the impact of peer providers in peer roles operating within traditional mental health service settings. Several of these studies found significant changes over time on a variety of outcome measures; yet, there were no significant differences between the experimental and comparison groups. For example, Davidson et al. (2004) and Rivera et al. (2007) found that psychiatric symptoms significantly decreased across experimental and control groups across time; yet, there were no significant differences between the experimental and control groups. Across the range of experimental rigor, five out of nine studies found that the addition of peer providers in traditional mental health service settings reduced inpatient service use, improved engagement in outpatient behavioral health treatment, and improved quality of life for mental health service users (Chinman et al., 2014).

Reduced inpatient service use. In Sledge et al. (2011), a randomized controlled study that examined the effectiveness and feasibility of using peer providers in peer roles to reduce

readmission rates for mental health service users with multiple psychiatric hospitalizations (i.e., more than two in eighteen months), the authors found that participants assigned to peer providers had significantly fewer admissions and fewer days in the hospital than those assigned to usual care. In another randomized study, Clarke et al. (2000) found that mental health service users receiving Assertive Community Treatment (ACT), an evidence-based model for treating adults with SMI (Boust, Kuhns & Studer, 2004), spent significantly more days in the community than others assigned to non-peer-staffed ACT teams. In Lander & Zhou's (2011) cross-sectional descriptive study, mental health service users assigned to peer providers in peer roles were significantly less likely to experience a psychiatric hospitalization than others who were not assigned to peer providers. However, other studies question whether the addition of peer providers in peer roles affects the utilization of inpatient service use.

In Van Vught et al. (2012) quasi-experimental study, mental health service users receiving peer support services from peer providers spent more days in inpatient psychiatric settings than others who did not have access to paid peer support. In other studies that examined inpatient service utilization and community tenure (number of days in the community), there were no significant between-group differences in readmission rates and number of inpatient days for participants who received services from peer providers to others who did not (Landers & Zhou, 2014; O'Donnell et al., 1999; Rivera et al., 2007; Schmidt et al., 2008). Pitt, Lowe, Hill, Prictor, Hetrick, Ryan, and Berends' (2013) systematic review of randomized trials that examined the use of peer providers in peer roles identified six studies that also found no significant differences in utilization of inpatient treatment services when mental health service users were assigned to peer providers.

Treatment engagement. Recent research highlights the utility of peer providers with engaging those who are alienated from or reluctant to participate in the behavioral health system (Davidson et al., 2012; Davidson et al., 2006; Solomon et al., 1995). Two randomized controlled trials (Craig et al., 2004a; Sells et al., 2006) and one quasi-experimental study (Felton et al., 1995) found significant differences in service engagement and participation for mental health service users assigned to treatment teams that employed peer providers than to those assigned to teams without peer specialists. The authors suggests that peer specialists understand the experiential world of adults with SMI and capitalize on sharing their histories and lived experiences of recovery to build credibility with mental health service users (Ashcroft, Campbell & Sanchez, 2014; Mead et al., 2001). As a result, adults with SMI assigned to teams that employ peer specialists are more likely to attend and participate in treatment (Sells et al., 2006).

Quality of life. In the Felton et al. (1995) quasi-experimental study, mental health service users served by teams with peer providers on staff reported fewer life problems, greater satisfaction with their living situation, and greater satisfaction with their overall finances. Repper and Carter's (2011) review on peer support identified a wider evidence base, including qualitative studies that identified empowerment, social support and functioning, empathy and acceptance, and hope as benefits to mental health service users receiving peer support in traditional mental health service settings. However, the Pitt et al. (2013) review of randomized control trials that compared outcomes of mental health service users with or without the addition of peer specialists in traditional mental health service settings found no significant differences in quality of life.

Benefits to peer providers as paid employees. Peer providers employed in traditional mental health service settings in peer specific roles have reported personal, social, and

professional benefits as a result of their employment. Personal benefits include increased feelings of self-efficacy and self-esteem (Johnson, Magee, Mary, Furlong-Norman, Rogers, & Thompson, 2014; Salzer & Shear, 2002), positive changes in self-image and self-acceptance (Moran, Russinova, Gidugu, Yeon Yim, & Sprague, 2012), enhanced sense of empowerment (Hutchinson et al., 2006), increased knowledge and activation of self-management skills (Moran et al., 2012), and financial remuneration (Mowbray, Moxley, & Collins, 1998; Salzer & Shear, 2002). Peer specialists have also described having found new meaning and positive appraisal of their own lived experiences with SMI (Johnson et al., 2014; Moran et al., 2012). Social benefits included the increased sense of interpersonal competence (Salzer & Shear, 2002), social connectedness, and positive changes to the size and constellation of their social networks (Moran et al., 2012). Professional benefits included the acquisition of transferable skills (Salzer & Shear, 2002) and possible mobility to other employment opportunities (Mowbray et al., 1998).

Benefits of employing peer providers for traditional mental health service providers. Dixon, Krauss, and Lehman (1994) were the first to publish their own experiences having implemented a model where mental health professionals and mental health service users advocates (peer providers in peer specific roles) collaborated on the same treatment team. Dixon et al. (1994) explained that mental health service users advocates were effective in locating lost service users based on their own knowledge of systems and lived experiences, offered unique insights and knowledge in navigating community resources, sensitized staff to medication side effects, engaged mental health service users by using language that was easily understood by service users, and challenged unacknowledged biases and prejudices towards service users by serving as role models of recovery.

In the Chinman et al. (2008) study that examined the integration of peers across the Veteran's Administration (VA), non-peer staff reported that peer providers increased veteran engagement in mental health services, helped veterans advocate for themselves in treatment team meetings, and identified community resources and supports outside the VA that helped veterans in their own recovery (Chinman et al., 2008). In Craig et al. (2004b) study that examined the presence of peer providers, non-peer providers reported changes in their own attitudes and behaviors towards service users, including use of person-centered language when speaking with or referring to mental health service users.

Barriers to Workplace Inclusion of Peer Providers

The literature describes a number of barriers to employment for peer providers, including role conflict and confusion (Cabral, Strother, Muhr, Sefton & Savageau, 2014; Chinman et al., 2008; Dixon et al., 1996; Gates & Akabas, 2007; Kemp & Anderson, 2012), role ambiguity, (Mowbray et al., 1998; Mowbray, Moxley, Thrasher, Bybee, & Harris, 1996), negative staff attitudes, (Chinman et al., 2008), and concerns regarding dual relationships (Dixon et al., 1994).

Role conflict and confusion. Peer providers may experience role conflict and confusion as they assume new professional identities as service providers (Carlson, Rapp, & McDiarmid, 2001). Davidson et al. (2006) describe the relationships between peer providers and mental health service users as falling along a continuum between asymmetrical and bi-directional. In mutual-aid settings, peer relationships are characterized as bi-directional and reciprocal – both parties mutually benefit from each other's experiences. In traditional mental health service settings, peer providers are believed to have advanced in their own recovery to a degree to which allows them to help mental health service users at varying levels of skill and recovery (Chinman

et al., 2014). In this arrangement, the mental health service user is the service recipient and the peer provider is the service provider. The relationship is characterized as asymmetrical.

The transition from mental health service user to mental health service provider complicates friendships between peer providers and mental health service users. Mental health service users may set unrealistic expectations for friends who become peer providers, while other mental health service users may resent their friends' success (Chinman et al., 2008). Delineating the boundaries between supporter and friend often complicates the relationships between peer providers and mental health service users.

Role ambiguity. The role and responsibilities of peer providers are often loosely defined and not clearly communicated to traditional mental health service staff (Chinman et al., 2008, 2012; Kemp & Anderson, 2012). Role ambiguity may lead mental health and other healthcare professionals to question and minimize the role of peer providers in traditional mental health service settings (Dixon et al., 1994). Lack of appropriate supervision (Davis, 2015) and lack of understanding regarding the role of peer support among supervisors and colleagues (Kemp et al., 2012) may lead to conflicting role expectations. Further, role ambiguity leads to increased anxiety and conscious decisions for peer providers to overextend themselves at work to counteract initial fears and assumptions made by other staff (Chinman et al., 2008). It has been suggested that role clarity is essential for the successful integration of peer providers into traditional mental health services settings (Davis, 2015).

Negative Staff attitudes. Carlson et al. (2001) highlights that peer providers and mental health professionals have both experienced discomfort in developing collegial relationships as equal members of treatment teams. Role conflict and confusion are antecedents for non-peer staff to treat peer providers as nonessential staff whose contributions are seen as less than equal in

terms of skills, abilities, and responsibilities (Carlson et al. 2001; Salzer et al., 2002). Further, health professionals are not immune from stigma and discrimination towards people with disabilities and other marginalized and oppressed groups. Stigma towards adults with SMI is widely prevalent among behavioral health professionals (Corrigan & Watson, 2002; Rao, Mahadevappa, Pillay, Sessay, Abraham, & Luty, 2009; Verhaeghe & Bracke, 2012). Chinman, et al. (2008) & Gates & Akabas (2007) found that stigma and discrimination towards peer providers is also widely prevalent among behavioral health professionals.

Dual relationships. Mental health professionals are expected to honor their respective disciplines' code of ethics that clearly describe the parameters of relationships between providers and their clients. In most health and human service disciplines, professionals are advised against entering or engaging in dual or multiple relationships with their clients. Dual or multiple relationships are situations in which service providers relate to service users in more than one relationship, whether personal, professional, or financial (Carlson et al., 2001). As Carlson et al. (2001) explains, dual relationships are considered unethical because of the potential risk of possible exploitation or potential harm to clients. The nature of relationships between peer providers and mental health service users is uniquely different from other providers. Peer providers may choose to utilize the same resources and supports (e.g., self-help groups) in their communities as their clients for their own recovery.

Carlson et al. (2001) highlights the ongoing debate on whether peer providers should be hired in behavioral health settings where they receive and provider services. Opponents emphasize that hiring peer providers from the same agency is unethical because of potential risks of harm or exploitation to peer providers (Carlson et al., 2001; Perkins, Buckfield, & Choy, 1997). Others point out that providers in primary care settings often choose to receive treatment

in the same setting where they are employed, and that concerns of peer providers entering dual relationships reflect pervasive and omnipresent forms of stigma of mental illness and mental health services (Perkins et al., 1997).

This chapter reviewed the historical context and evolution of peer support in traditional mental health service settings. It began with a brief overview of SMI, an introduction to the recovery paradigm, a brief history of the mental health consumer and psychiatric survivor movement, recovery-related outcomes for mental health service users receiving support from peer providers, benefits to mental health service users who receive peer support services, benefits to mental health services providers who employ and integrate peer specialists into traditional mental health service settings, and the experiences of peer providers in other systems as paid employees. It ended with an overview of barriers towards employing peer providers in traditional mental health service settings.

According to Kaufman et al. (2017), 190 individuals have been trained and certified in Hawaii as peer specialists. As highlighted throughout this chapter and in the introduction, there remains no information on why mental health service users in Hawaii choose to become peer specialists, what motivates mental health service users to apply for the program, and what impact the program has on their recovery. It is not known what happens to peer specialists in Hawaii after they become certified.

CHAPTER 3: METHODS

This study examined the perspectives and recovery experiences of Hawaii's mental health service users in becoming peer providers. This chapter begins with the theoretical framework, rationale for using qualitative methods, site selection, sampling, data collection and analysis procedures, validation procedures, and ethical considerations when engaging vulnerable populations in research.

Theoretical Framework

A critical perspective provides an overall orienting lens and framework for the study of marginalized or underrepresented groups (Creswell, 2009). Creswell (2009) explains, "This lens becomes an advocacy perspective that shapes the types of questions asked, informs how data are collected and analyzed, and provides a call for action or change" (p. 62). Use of a theoretical lens guides researchers on their position in the study and how final accounts are written (Creswell, 2009). Critically-oriented researchers seek to understand and explain phenomena and aim to critique and change systems or society as a whole (May, 2004; Patton, 2002).

Critical Theory. Critical theory evolved from the work of Max Horkheimer, Theodore Adorno, and Herbert Marcuse, three scholars who formed the Frankfurt School in the German Weimer Republic in 1923 (Brookfield, 2005). The original Frankfurt tradition that identified with classical Marxist theory has evolved to include a wide range of social inquiry and perspectives with the practical aim of empowering underrepresented groups by transcending the constraints placed on them by race, class, gender, disability, education, religion, sexuality, geography, or the intersectionality of these differences (Creswell, 2009, 2013; Kincheloe & McLaren, 2000). Inquiry that aspires to be critical confronts the injustices of a particular society or system.

Kincheloe and McLaren (2005) explain that defining critical theory is difficult since "(a) there are many critical theories, not just one; (b) the critical tradition is always changing and evolving; and, (c) critical theory attempts to avoid too much specificity, as there is room for disagreement for critical theorists" (p. 303). Yet, there are commonalities across critical schools of thought.

Critical theories aim to critique and change society, not name or describe phenomena from a particular vantage point (Brookfield, 2005). Critical inquiry is fundamentally and explicitly political; critical theorists eschew any pretense of objectivity or open-mindedness (Brookfield, 2005; Patton, 2002). Critical theorists reject universal truths and objective facts; interpretations of experiences are contextual. "Facts are believed to be local. They exist within a particular context which is relative over time and space and are consequently socially constructed" (Morley, 2003, p. 65). Inquiry that aspires to be critical confronts the injustices and subjugations of a particular society or system(s).

Brookfield (2005) describes five distinct characteristics that differentiate critical theories from others. First, critical theory is grounded in a particular political analysis. The primary unit of analysis is the "conflicting relationship between social classes within an economy based on the exchange of commodities – remains stable, at least until society has been radically transformed" (Brookfield, 2005, p. 23). Within this economy, tensions are inevitable when oppressed classes desire emancipation, while others in power prevent this desire from being realized. The second characteristic of critical theory is its concern of generating knowledge to free people from oppression and to bring about social change. Critical theory's capacity to inspire action is an important measure of its validity. The third characteristic of critical theory is that it removes artificial barriers or separation of the researcher and her or his focus of research.

The validity of this theory derives partly from the premise that oppressed and disenfranchised populations support the philosophical vision of a just and fair society. The fourth characteristic is that critical theory conceives the possibility of a fairer, more democratic, and less alienated society. It envisions an equitable world as it might be. The final distinctive characteristic is "the fact that verification of [critical] theory is impossible until the social vision it inspires is realized" (Brookfield, 2005, p. 29).

Critical Disability Theory. Critical theories aspire to emancipate and challenge economic, legal, political, and social oppression; yet, Oliver (1998) argues that critical theories have tended to indirectly benefit people with disabilities. Critical theories, in the past, have raised political awareness and "publicized disabled peoples' critical views on health care" (Oliver, 1998, p. 1448). Despite variations in critical theories (e.g., Critical Race Theory), none, until recently, have directly addressed the coercion, marginalization, oppression, and social exclusion of people with disabilities (Devlin & Pothier, 2006).

Rocco (2005), Devlin and Pothier (2006), and Hosking (2008) offer three similar conceptualizations of Critical Disability Theory (CDT), an emerging theoretical framework that addresses the inadequacies of existing critical theories on the study and analysis of disability issues. Rocco (2005) proposes six principles, Devlin and Pothier (2006) reference four central themes, and Hosking (2008) identifies seven elements. CDT is an extension of Disability Studies, and other critical theories, including Critical Legal Studies, and Critical Race Theory. As an emerging theoretical framework, no one has been identified in the literature as the authority in CDT. None of the principles proposed by Rocco (2005), Hosking (2008), or Devlin and Pothier (2006) contradicts the others, and in fact, most coincides and compliments other elements.

In all three frameworks, the authors propose theory that pursues empowerment and substantive equality for all people with disabilities. CDT, as a critical theory, is explicitly political - it aims to change society by pursuing empowerment and substantive equality for people with disabilities (Devlin & Pothier, 2006). This pursuit begins by critically examining issues of power and context. This examination questions "who and what gets valued, and who and what gets marginalized" (Devlin & Pothier, 2006, p.9).

The following nine elements incorporate and distill the essence of principles proposed in Rocco's (2005), Devlin & Pothier's (2006), and Hosking's (2008) conception of CDT:

1. Disability is socially and culturally constructed.
2. Language used in the discourse of disability is inherently political.
3. Citizenship entails a capacity for productivity.
4. Commodification exploits and marginalizes people with disabilities.
5. Disability exists along a continuum of human variation and is multidimensional.
6. Ignoring diversity limits equality and full participation of people with disabilities.
7. Self-determination and equality are contingent on true minority group status.
8. Ableism is so ordinary and pervasive that it is invisible to the non-disabled.
9. The voices and perspectives of people with disabilities are deftly suppressed.

Disability is socially and culturally constructed. "Disability has no essential nature… persons are manufactured as disabled" (Devlin & Pothier, 2006, p. 5). Social and cultural contexts construct definitions of disability. There is no consensus on what and who qualifies as disabled. Defining disability may have cultural, economic, personal, social, and political implications (Rocco, 2005). Devlin and Pothier (2006) highlight the contentious nature to the politicization of a disabled identity for specific conditions. For example, there may be agreement

by many within a particular setting that blindness qualifies as a disability, whereas substance use disorders and their impact on a person's daily activities of work, leisure, and living may not qualify as a disability.

There are two major schools of thought regarding how disability is perceived, diagnosed, and treated (Rioux & Valentine, 2006). The dominant discourse on disability has been framed by the medical model, which locates disability to individual pathology and personal misfortune arising from functional limitations (Barnes, Mercer & Shakespeare, 1999; Hiranandani, 2005; Lalvani & Polvere, 2013). This deficits-based construction of disability has dominated assumptions, beliefs, perspectives, questions, methodologies, and analyses used in disability research. The second identifiable formulation of disability is based on social pathology. The Social Model of Disability, first articulated by the Union of the Physically Impaired Against Segregation, rejects the medical interpretation of disablement and asserts that society perpetuates the oppression and exclusion of people with disabilities (Beckett, 2006; Johnstone, 2001). From this perspective, Rioux and Valentine (2006) highlight, "disability is identified as a consequence of the barriers in society that restrict participation of people with impairments of disabilities in economic and social life" (p. 52).

Hosking (2008) proposes a hybrid version of the social model in his conceptualization of CDT that incorporates aspects of the medical model based on the argument that (1) disability is a social construct, (2) "disability is best characterized as a complex interrelationship between impairment, individual response to impairment, and the social environment," and (3) the interactions of attitudinal, institutional, physical, and social variables which create disablement for individuals who do not meet societal expectations of normalcy. Hosking's (2008) conceptualization of CDT accepts the biopsychosocal model (Engel, 1977) of disability that

recognizes and aims to balance the practical realities of impairments, the personal response and interpretation of impairment, and structural and personal barriers imposed by society.

Language used in the discourse of disability is inherently political. According to Hosking (2008), "language influences the concept of disability and the status of disabled people" (p. 13). There are two themes for this element. First, the range of descriptors, terms, and labels used when referring to persons with disabilities reflects a continually evolving process with ideological and political implications (Devlin & Pothier, 2006). For example, the term *handicapped,* which was only recently dropped from general use, conveys a negative connotation that suggests entire persons are disabled because of their impairments. The word impairment itself is ideologically loaded. Currently, person-first language (e.g., adults with schizophrenia) is used when describing people with disabilities, and it is assumed that this descriptor, term, or label may also change as the word disability, itself, is contested and problematic (Devlin & Pothier, 2006). The word disability has pejorative and exclusionary origins (Devlin & Pothier, 2006). Hosking (2008) suggests that labeling processes repeat themselves when labels reference something in society that is considered to have a negative attribute.

Second, the words and images used to describe and portray people with disabilities directly impacts and influences social attitudes towards people with disabilities (Hosking, 2008). Historically and today, mainstream cultural and media representations and imagery of people with disabilities has a potent, if not direct, effect on able-bodied audiences (Barnes & Mercer, 2003). For example, media coverage on people with SMI is dominated by negative storylines that influences and impacts audiences, including potential and current users of mental health services and their social relationships (Barnes et al., 1999).

Citizenship entails a capacity for productivity. Productivity and employment are highly valued in Western societies, and as a result, there is a tendency to assume that full citizenship and personhood entails a capacity for productivity (Devlin & Pothier, 2006). CDT posits that institutional discrimination and disabling barriers maintain inequalities in income and employment for people with disabilities (Barnes & Mercer, 2003; Beckett, 2006; Rocco, 2005). People with disabilities who are competitively employed earn less than people without disabilities (Erickson, Lee, & von Schrader, 2016), and earn less for performing the same work (Rocco, 2005). In addition, disabling barriers often present indirect costs associated with maintaining or participating in competitive employment (e.g., specialized transportation) resulting in lower net income to the individual's or family's household. Devlin and Pothier (2006) argue, "Efficiency and productivity are irretrievably ableist discourses that can only condemn (some) persons with disabilities to a presumptive inferior status" (p. 18).

Commodification exploits and marginalizes people with disabilities. Hiranandani (2005) highlights, "Disability has been institutionalized and rehabilitation goods and services have become commodified in an ever expanding market… people with disabilities have become consumers" (p. 4). Yet, healthcare and social service professionals, rather than the consumer, assume a social status that creates an unequal power relationship between the two (Swain, French & Cameron, 2003). Professionals exercise control over people with disabilities by assessing and labeling them, defining their problems, and recommending a specific course of action (Barnes & Mercer, 2003; Swain et al., 2003). Exploitation, marginalization, and oppression of people with disabilities are maintained through the actions and self-serving interests of healthcare and social service professionals that "serve" people with disabilities (Barnes & Mercer, 2003; Rocco, 2005).

Disability exists along a continuum of human variation and is multidimensional. Ableist norms maintain binary conceptions of disability (i.e., disabled versus non-disabled) that ignore the diverse nature and continuum of human variation (Procknow, Rocco & Munn, 2017; Rocco, 2005). There are two general themes for this element. First, disability is dynamic and contextual. The context, setting, and situation in which a person with a disability resides determine its significance. Devlin and Pothier (2006) explain, in some situations, the disability is factored in, and in other situations, it is ignored. Further, the visibility of disabilities is also contextual; the disability may not be apparent unless the person is asked to engage in an activity that may require an accommodation.

Second, disability is not a mutually exclusive category of experience and analysis (Hosking, 2008). Disability intersects with other socially constructed classifications, including but not limited to: class, gender, race, ethnicity, and sexual orientation (Hosking, 2008; Devlin & Pothier, 2006). Hosking (2008) highlights, "Multidimensionality describes the presence of the multiple interconnected memberships which individuals have as they go about their daily lives" (p. 10). These socially constructed categories may also have histories of domination, oppression and subordination and should be factored into any analysis of disability (Devlin & Pothier, 2006).

Ignoring diversity limits equality and full participation of people with disabilities. The range and diversity of disability are enormous. Ableist norms engender exclusion by ignoring differences among people with disabilities (Devlin & Pothier, 2006). Dismissing differences has the potential to further reject and marginalize people with disabilities (Hosking, 2008). It is also difficult to use an identifying characteristic as an organizing principle without potentially excluding members and making diversity within the group disappear (Devlin & Pothier, 2006). Inclusion and full participation of people with disabilities demands that differences be

acknowledged and understood as inevitable and expected. The challenge of acknowledging difference is preventing the creation of hierarchies – "either between disability and non-disability or within disability" (Devlin & Pothier, 2006, p. 12). Hosking (2008) highlights, "being identified, and identifying, as a disabled person is central to understanding one's self, one's social position with its attendant opportunities and limitations, and one's knowledge of the world" (p. 11).

Conceptualizing disability as personal misfortune has profound implications in policies that impact people's rights to autonomy, equal opportunity, and full participation in society (Hosking, 2008). If the starting point to disability is personal misfortune or bad luck, the first level of response from a disabling society is prevention (Devlin & Pothier, 2006). If prevention is not achieved, the next level of response is on treatment and cure. Here, the medical model takes precedence and introduces various interventions, often extraordinary, to eliminate the impairment (Devlin & Pothier, 2006). If neither prevention nor cure is attained, the last resort of a disabling society to engage people with disabilities is rehabilitation (Devlin & Pothier, 2006). The emphasis of rehabilitation is on coping and adaptation. The authors contend that prevention, treatment, and rehabilitation are not necessarily bad; however, Devlin and Pothier (2006) argue,

> To start from the perspective that disability is misfortune is to buy into a framework of charity and pity rather than equality and inclusion. To contextualize and conceptualize disability, as personal misfortune, is to create a hierarchy of difference – fortune must be better than misfortune (p. 10).

Devlin and Pothier (2006) suggest that disabling societies have difficulty rejecting hierarchies of difference as evident in the tension between policies that promote social welfare and policies that ensure civil rights and equality for all citizens.

Self-determination and equality are contingent on true minority group status. Ableist assumptions that conceptualize and maintain that disabilities are individual anomalies (Devlin &

Pothier, 2006) prevent some people with disabilities from exercising their right to self-determination (Rocco, 2005). Rocco (2005) defines self-determination using the National Council on Disability's (formerly the National Council on the Handicapped) definition of independent living as having "control over one's life based on the choice of acceptable options that minimize reliance on others making decisions and in performing everyday activities" (p. 4).

Self-determination will never be fully realized among all people with disabilities until full and equal civil rights protections in law are codified and enforced (Schroeder, 2015). Schroeder (2015) highlights that "people with disabilities have some civil rights protections, but not the same protections afforded to ethnic minorities and other protected classes of individuals" (p. 5). Schroeder (2015) is critical of specific language used in the Americans with Disabilities Act of 1990 that refers to *qualified individuals*. The concept of *qualified individuals* is not contained in similar laws barring discrimination against other minority groups (e.g., Civil Rights Act of 1964). For instance, there is no such concept as qualified woman or qualified individual from a specific race or ethnic background. Schroeder (2015) argues:

> While not explicitly stated, it is assumed that people are not inherently inferior by virtue of race, color, religion, sex or national origin. In other words, it is understood that they are inherently normal people, capable people, people whose lives are unjustly constricted by prejudice. They are not required to prove that they are qualified, because they are assumed to be qualified; they are assumed to be equal in capacity and ability. They are not informed nor limited by their minority status but by prejudice. But the same is not assumed to be true for people with disabilities (p. 5).

Ableism is so ordinary that it is invisible to the non-disabled. Ableism is defined by Linton (1998) as discrimination in favor of the able-bodied, the notion of people with disabilities are inferior to non-disabled people, and the idea that a person's abilities or their characteristics are defined by their disability. Able-bodied norms are assumed as "natural, normal, inevitable, necessary, even progress" (Devlin & Pothier, 2006, p. 7). Most activities of daily living are

organized on able-bodied assumptions that force people with disabilities to make accommodations themselves to the social and built environment (Rocco, 2005). For example, the growing expansion of cities is built on able-bodied assumptions (e.g., individuals have perfect vision or may choose to use corrective lenses) that people can drive without experiencing significant barriers in their daily commute (Devlin & Pothier, 2006); yet, most automobiles are primarily built for the non-disabled and public transportation systems, if available, may only accommodate specific impairments (Barnes et al., 1999).

As described earlier, the visibility for some people with disabilities is contextual. Devlin and Pothier (2006) highlight the possibility and politics for people with hidden disabilities (e.g., mental illness) to *pass* as able-bodied. "If marginalization or discriminatory consequences are associated with being categorized as disabled, there may be an inventive to act as thought one is not disabled" (Devlin & Pothier, 2006, p. 15). Even when people with disabilities make no attempt to *pass*, ableism assumes normalcy and expects people to act in able-bodied ways. Further, people with disabilities may go through extraordinary efforts to pass as able-bodied (Devlin & Pothier, 2006).

Voices and perspectives of people with disabilities are deftly suppressed. Historically and today, the voices, experiences, and perspectives of people with disabilities who challenge mainstream conceptions of disability have been deftly silenced and ignored (Hosking, 2008; Procknow et al., 2017). Hosking (2008) argues,

> When the disabled voice says what the able-bodied perspective wants to hear, it is heard; when it says something that the able-bodied perspective does not want to hear, it can simply be dismissed as the inappropriate response of a person who has developed an unhealthy response to the impairment (p. 12).

Rocco (2005) suggests that labels for specific impairments, rather than the complex experience of living in a disabling society, become the defining characteristic for people with disabilities.

CDT privileges the stories of people with disabilities to counter efforts and practices that reinforce suppression of marginalized voices (Hosking, 2008). CDT suggests that mental health service users experience multiple, often conflicting, realities. Their interpretations of these realities are situated and exist in relation to a particular context and setting (Morley, 2003). Hosking (2008) highlights, "critical disability theory privileges the voices of disabled people and relies on their voices to challenge the negative attitudes toward disability commonly expressed by able bodied people" (p.17).

This study assumes a critical perspective that focuses on issues of power and the ways that various social institutions construct social systems and shape social realities (Patton, 2002). Critically-oriented researchers recognize that society and science have embraced dominant forms of consciousness and knowledge without considering the relationships between the social context in which researchers are situated and the formation of their propositions (May, 2004). As a critically-oriented researcher, I am particularly interested in how oppression, suppression, and other structural determinants reinforce inequalities and injustices that shape peer providers' experiences and perspectives (May, 2004; Patton, 2002). This epistemological position differs from Western-oriented positivist standpoints and assumptions of knowledge and research objectivity (Patton, 2002).

Qualitative Methods

Qualitative methods were chosen for this study based on the nature of the research questions and my positionality as a non-disabled, critically-oriented researcher. According to Corbin and Strauss (2015), an underlying assumption of using qualitative methods is that "concepts pertaining to a given phenomenon have not been identified, or aren't fully developed, or are poorly understood, and further exploration is necessary" (p.35). Creswell (2013) explains

that qualitative methods are best suited for exploring problems or issues when the aim is to empower individuals to share their stories and hear their voices unencumbered by what we expect to find. Creswell (2013) emphasizes that this exploration allows for detailed understanding of complex issues that can only be established by engaging participants to understand the contexts and settings in which they address the problem or issue. Methods used in qualitative research are characterized as "inductive, emerging, and shaped by the researcher's experience in collecting and analyzing data" (Creswell, 2013, p. 22).

This study used grounded theory to guide the inquiry in collecting and analyzing HCPS's perspectives and lived experiences of being a peer provider. Glasser and Strauss (1967) developed grounded theory, a qualitative methodology that offers systematic analytic strategies for generating theory. The methods and processes used in grounded theory moves qualitative inquiry beyond descriptive studies to explanatory theoretical frameworks (Charmaz, 2006). The emphasis of grounded theory is on "inductive strategies of theory development in contrast to theory generated by logical deduction from a priori assumptions" (Patton, 2002, p, 125). Glasser and Strauss (1967) explain that "generating a theory from data means that most hypotheses and concepts not only come from the data, but are systematically worked out in relation to the data during the course of research" (p.6).

Grounded theory employs specific methods and systematic procedures from initial design, through data collection and analysis (Patton, 2002). Corbin and Strauss (2015) explain that grounded theory offers a framework that is both systematic and substantively creative at the same time. This structured flexibility and freedom to explore a topic allows researchers to gain insights into old problems, as well as study new and emerging areas in need of investigation (Charmaz, 2008; Corbin & Strauss, 2015). Although Glaser and Strauss would go on to develop

their own versions of grounded theory (Charmaz, 2006, 2008; Corbin & Strauss, 2015), the fundamental and defining components of grounded theory, according to Charmaz (2006, 2008) include:

- Minimization of preconceived ideas about the research problem;
- Remaining open to different explanations throughout each stage of research;
- "Constructing analytic codes and categories from data, not from preconceived logically deduced hypotheses" (Charmaz, 2006, p.5);
- Simultaneously collecting and analyzing data to inform each other;
- Constantly comparing data (i.e., constant comparison method) at each stage of analysis;
- Advancing theory at each stage of data collection and analysis;
- Using memo-writing to develop and define codes and categories to examine their relationships and to identify gaps;
- Sampling towards theory construction, not population representativeness; and
- Delaying the literature review until after developing an independent analysis.

Charmaz (2006, 2008) argues that both Glasser's and Strauss and Corbin's versions of grounded theory are highly structured and more positivistic than later versions of the method. Charmaz described that many grounded theorists are objectivists in orientation (Corbin & Strauss, 2015; Patton, 2002). Objectivists assume positivistic assumptions of an external world that could be described, analyzed, explained, and predicted in similar ways (Charmaz, 2006; Patton, 2002). Charmaz (2006) suggests that neither data nor theories are discovered – we construct grounded theories "through our past and present involvements and interactions with people, perspectives, and research practices" (p. 10). Unlike objectivists, constructivists contend that everyone involved, including the researcher, become part of the research process and product (Charmaz,

2008). Concepts and theories are constructed by researchers through narratives created by participants who have been asked to explain and make sense of a phenomenon or experience (Corbin & Strauss, 2015). The constructionist approach to grounded theory means learning "how, when, and to what extent the studied experience is embedded in larger and often, hidden positions, networks, situations, and relationships" (Charmaz, 2006, p. 130). This approach requires the researcher to be alert to conditions where difference and distinctions between people, especially hierarchies of power, communication, and opportunity, arise and are maintained. Constructivists recognize that their perspectives may evolve and change as they engage with research participants and with their data. Data analysis is contextually situated (Charmaz, 2006) and seen as an iterative and interactive process (Corbin & Strauss, 2015). Constructivists offer interpretive portrayals of the world aimed at understanding, rather than explaining the studied phenomenon (Charmaz, 2006).

Recruitment

Two peer providers agreed to serve as advisors who provided me with recommendations on recruiting and interviewing HCPSs. Both recommended that recruitment efforts should begin by directly contacting HCPSs who were employed in traditional mental health service settings. I was discouraged from sending email correspondence to HCPSs or to their places of employment without first contacting them by phone. The advisors explained that HCPSs may prefer correspondence be sent to their personal email addresses, rather than their work email address, and that HCPSs may refuse participation if their employers became aware of their involvement. In addition, I was advised against using social media, the Hawaii State Department of Health's Office of Consumer Affairs, or the State's only consumer-run support and advocacy organization to recruit HCPS. The advisors warned of the real potential of reprisal against HCPSs who spoke

negatively of their employer, their colleagues, the system, or about other HCPSs. I was specifically advised to not collect or report on demographic data. Both advisors described several instances and identified specific HCPSs by name that experienced retaliation from their employers and from the system for having been critical of the program.

Participant selection process. Initially, HCPSs were contacted by phone. I briefly described the purpose of the study, and asked whether they would be interested in learning more about the study. Prospective participants who expressed interest were asked for their preferred email address and for their permission for me to send a recruitment flier (see Attachment C) and a copy of the informed consent form (see Attachment D). I also offered to send all materials by standard mail. The recruitment flier contained information regarding the purpose of the study, inclusion criteria, time commitment, and my telephone number. As described in the flier, HCPSs were advised to contact me by phone to protect their confidentiality. Participants were also told that a current email address was not required to participate in the study, and for participants with a current email address, they may also choose to not have anything sent to them. Prospective participants who chose to have materials sent to them by email were asked to forward the email invitation to other HCPSs, including HCPSs who were employed outside the mental health service system, HCPSs employed in the behavioral health system but in non-peer positions, and HCPSs who were unemployed.

Ten prospective participants contacted me by phone to indicate their interest in participating in the study. I established contact with nine. I described the agenda and what participants should expect throughout the interview. I welcomed and answered questions about the study prior to scheduling interviews. I spent a significant amount of time addressing and assuring participants that all interviews would be confidential and agreed to provide no

information that would potentially compromise their anonymity. I emphasized that participation was voluntary. Most participants expressed serious concerns regarding potential reprisal during the recruitment period and again when reviewing the informed consent form.

HCPSs who agreed to participate in the study were asked for their preference on specific dates and times of interviews. Participants on the island of Oahu were given the option to complete interviews in-person or by phone, whereas other participants on other islands across the state were limited to telephonic interviews. Face-to-face interviews were conducted in agreed-upon community settings that were accessible, convenient, private, safe, and secure. Telephonic interviews were conducted in private places where participants reported feeling safe and that they could freely speak without being heard by others. All participants were encouraged to contact me anytime before and after the interview if they had questions about the study.

All interviews began with a review of the meeting agenda. I read the informed consent form in its entirety and would stop at the end of each section and ask whether the participant had questions. Next, I asked a set of questions (see Appendix E) to ascertain participants' understanding and ability to provide informed consent and to ensure individuals understood their rights as research participants. I asked participants whether they felt safe and secure in the location where the interview took place. I reminded participants of their right to not answer questions asked in the interview and their right to terminate the interview at any time for any reason. I explained in detail how recordings would be transcribed and destroyed.

Participants were offered to continue interviews even if they chose not to have their interviews recorded. I explained the interviewing process where interviews that were not recorded would involve me typing answers to questions asked using word processing software

on a secure, password-protected laptop. I would repeat back what had been recorded to ensure accuracy.

The orientation of the interview agenda and review of the informed consent form ranged from 11 to 34 minutes. Participants engaged in informal conversations with me before interviews began, often causing the orientation and review of consents to take much longer than expected. Informal conversations before and after any type of meeting, often referred to as *talk story*, is common and expected in Hawaii. I welcomed questions during this period to ensure participants felt safe and comfortable with the interview. I was asked numerous questions including my intent and rationale for conducting the study, familiarity of the HCPS program, whether I was from Hawaii, and the communities where I grew up. I was also told during this period that the HCPSs who chose to participate in the study did so because of the endorsement of other HCPSs. None of the informal conversations were recorded; however, themes from our discussions were incorporated into my personal memos.

Inclusion criteria. Eligible participants included: (1) individuals 18 years of age and older who self-identify as being trained and certified by the Hawaii State Department of Health as a HCPS, (2) had a history of employment or completed an internship as a peer provider in a traditional mental health service setting in Hawaii, (3) answered all questions asked in the informed consent form screening questionnaire (see Appendix E) correctly, and (4) consented to participating in the interview.

Exclusion criteria. Participants were excluded from the study if (1) they presented signs of severe cognitive or psychiatric impairments that affected their ability or understanding of interviewing procedures, and (2) participants failed to correctly answer screening questions asked in the informed consent form questionnaire found in Appendix E.

Sample. Nine HCPS agreed to participate in the study; however, eight (n=8) HCPS were interviewed. One of the HCPS was excused before the interview orientation period. The participant acknowledged experiencing distressing symptoms that necessitated a timely intervention. The prospective participant was advised to seek treatment and welcomed to meet with me at a later date to discuss their perspectives and experiences.

All participants were 18 years of age or older and self-identified as HCPSs. Interviews lasted between 45 and 142 minutes. Interviews were conducted between December 2016 and May 2017. Seven interviews were digitally recorded; one participant asked that their interview not be recorded. All digital recordings were transcribed verbatim. Once transcribed, all recordings were deleted. Participants were informed that transcriptions would be available within one week of the interview and that they were welcomed and encouraged to review the transcripts. None of the participants requested a copy of their transcripts. The participant who chose not to have their interview transcribed agreed for me to type their responses and read back their responses for accuracy.

All participants acknowledged having received mental health treatment, yet none received services from a peer specialist prior to or after receiving their HCPS certification. Only one participant was familiar with the HCPS program prior to applying.

Data analysis began with recruitment and throughout the entire duration of the study. As outlined earlier, grounded theory use a constant comparison method that guides sampling. Charmaz (2006) explains, "theoretical sampling pertains only to conceptual or theoretical development – it is not about representing a population or increasing the generalizability of your results" (p. 101). As categories emerged, I used memos to elaborate, delineate, define and refine the categories, their properties, and the relationship between these properties and the categories.

Dey (1999) argues, "Saturation has connotations of completion… but the confirmation of the ideas so generated is incomplete, since it leaves their verification to further research" (p. 116). Dey (1999) offers use of the term *theoretical sufficiency* to better represent the tentative status of categories and potential theories that emerge from use of grounded theory. Dey (1999) explains, "Theoretical sufficiency… refer[s] to the stage at which categories seem to cope adequately with new data without requiring continual extensions and modifications" (p. 117). I stopped interviewing participants when new sources of data, and the interpretation and reinterpretation of existing data through use of the constant comparison method, reached a stage of theoretical sufficiency. My sample included peer specialists from different cohorts across the State who had been employed as a peer specialist or completed an internship as a HCPS in a traditional mental health service setting and had history of receiving mental health services in Hawaii.

Data Collection

Interviews. This study used in-depth, semi-structured, intensive individual interviews using an interview guide (see Appendix F) to facilitate in-depth exploration of lived experiences of HCPSs. All participants were asked questions from the interview guide. The sequencing of questions often changed depending on participant responses to previous questions and the direction of the interview itself. After participants responded to each question, I used reflective listening (Miller & Rollnick, 2013) to convey interest and understanding and to encourage greater exploration of participant thoughts, feelings, and beliefs. In addition, I used follow-up probes to clarify my understanding of participant's experiences and perspectives (Charmaz, 2014). Data collection continued until categories became saturated - "categories are saturated when gathering fresh data no longer sparks new theoretical insights" (Charmaz, 2006, p.113).

Building trust. Throughout the interview, I would highlight and ask whether specific information offered by the participant could potentially compromise their anonymity. If participants agreed, the participant and I would identify what information should be removed from transcripts. All participants whose interviews were recorded would identify specific information to not include information in their interview transcripts. In addition, participants would begin or end responses with a request to not record specific information. At times, participants and I would negotiate and agree to include specific themes from their experiences with the understanding that direct quotes would not be included if we believed that the quote would compromise their anonymity. My knowledge of the HCPS program helped me to identify and clarify whether specific information was unique to specific cohorts. In addition, information presented by the participants clearly identified unique data that was specific to one or more cohorts.

Documents. I reviewed the following documents that were specific to or referenced the HCPS program: (1) Hawaii State Department of Health Adult Mental Health Division's HCPS Handbook (2012), (2) Appalachian Consulting Group's (2006a) Georgia Certified Peer Specialist Project's Facilitator's Guide, (3) Appalachian Consulting Group's (2006b) Georgia Certified Peer Specialist Project's Participant's Manual, and (4) and Centers for Medicare and Medicaid Services (CMS; 2013) Approval Letter to the Hawaii State Department of Human Services' Medicaid State Plan Amendment 13-004c.

Data Analysis

First-level analysis and interpretation. All recordings were transcribed and entered into NVivo for Mac (Version 11; QSR International, 2017), a qualitative data analysis software (QDAS) program. NVivo supports analysis of qualitative data with resources and tools for

indexing and coding internal and external data sources into conceptual or thematic nodes (i.e., codes); organizing, reducing, linking, or categorizing nodes; documenting annotations and memos; running queries and searches to examine patterns in the data; adding nominal and other categorical data for the purpose of comparing cases; developing visual models and charts; and generating reports (Bazeley & Jackson, 2013).

I began my analysis with initial coding. Initial coding involves line-by-line coding of interview transcripts with gerunds (Charmaz, 2006). Charmaz (2014) suggests, "coding for action reduces tendencies to code for types of people" and prevents researchers from adopting extant theories and concepts before having completed the necessary analytic work (p. 116). All codes using NVivo are stored as nodes (Bazeley & Jackson, 2013). Nodes reference the location of text coded in source files. Each node succinctly accounted for, categorized, labeled, named, and summarized segments of data (Charmaz, 2014). Nodes reference one element, concept, or category.

Initial codes were constantly compared (Glaser & Strauss, 1967) by identifying and grouping data together based on similarities and differences (Charmaz, 2014). Initial impressions, insights, reflections, and spontaneous thoughts about interview data were documented in the source file as annotations. Annotations, developing ideas, field notes, observations, unrecorded comments, and analytic insights and reflections about concepts or categories were documented in memos (journals). Memos also accounted for my thoughts and reflections on the meaning or significance from interviews or participant responses to specific questions. Microanalysis and focused coding was used to make meaning of data and to organize the most frequent and most significant codes into concepts and categories (Corbin & Straus, 2015). Nodes were later merged together or organized into branch hierarchies to create order, give meaning, and to support my

analysis with identifying patterns, contradictions, and emerging themes. Top-level (i.e., parent) nodes served as themes and child-level nodes served as subthemes.

Second-level analysis using critical disability lens. My initial analysis aimed to empower peer providers to share their stories and hear their voices unencumbered by any hypothesis or propositions (Creswell, 2013). The first level of my analysis identified themes that captured the essence of the peer provider's experiences and perspectives. In my second-level analysis, I analyzed and interpreted the experiences and perspectives of participants through the lens of Rocco's (2005), Devlin and Pothier's (2006), and Hosking's (2008) conception of CDT.

Methodological Considerations

All researchers bring values and biases to their studies, and in qualitative research, the researcher should make their values and biases known (Creswell, 2013). Patton (2002) suggests that inquirers' perspectives be made explicit regardless of tradition or training when reporting findings and interpreting meaning. Qualitative researchers admit the value-laden nature of their studies and value-laden nature of data (Creswell, 2013). I began this study with discussing my positionality and potential bias.

In qualitative research, the concept of validation refers to the accuracy or plausibility of the study's findings (Crewell, 2016). Essentially, validation refers to the ability of a study to demonstrate its credibility in terms of trustworthiness and authenticity (Creswell, 2013). Creswell & Miller (2000) suggest specific validation procedures for establishing credibility based on the researcher's lens (the viewpoints of the individuals conducting, participating, reading and reviewing a study) and philosophical orientation and assumptions. The procedures referenced by Creswell & Miller (2000) are used across various types of qualitative research, but tend to be emphasized more for specific paradigms (Patton, 2002). For this study, respondent

validation, researcher reflexivity, prolonged engagement, and peer debriefing were implemented for establishing validity.

Respondent validation. Respondent validation, also referred to as member checking, refers to the process of soliciting feedback on preliminary or emerging findings with participants (Meriam & Tisdell, 2016). Two of the participants were randomly selected and agreed to meet with me one month following their interview to review transcripts, preliminary themes, and nodes. Neither participant wanted a copy of their transcripts; however, both agreed to have me read excerpts from their interviews to determine whether I accurately recorded what they said and whether themes I found succinctly captured the essence of their interview. Both indicated and were surprised that excerpts from their interviews were transcribed verbatim, and that themes accurately captured the essence of what they were communicating. I highlighted portions of the interviews that were removed from transcripts. Both verbalized and emphasized their appreciation for removing these portions as both agreed that their responses would potentially identify them. A third participant agreed to meet briefly to only review themes from their interview. This participant also agreed that themes from their interview accurately captured the essence of their perspectives and experiences.

Role of the researcher (researcher reflexivity). Reflexivity, or positioning myself as the researcher, acknowledges the biases, values, and life experiences I bring to the study (Creswell, 2013, 2016). According to Patton (2002), "Reflexivity reminds the qualitative inquirer to be attentive to and to conscious of the cultural, political, social, linguistic, and ideological origins of one's own perspective and voice as well as the perspective and voices of those one interviews and those to whom one reports" (p. 65). Patton (2002) suggests for qualitative inquirers to write in an active, first person narrative to bring awareness and attention to these

perspectives. Creswell (2016) believes that reflexivity is comprised of two points: (1) describing my own "experiences with the phenomenon being explored" and how these experiences influence my interpretations (p 223).

In Chapter 1, I described my positionality and acknowledged the different roles I have assumed in working with HCPSs in different capacities as a clinician, consultant, and program evaluator. My clinical experience in behavioral health began with me co-facilitating groups with a peer specialist in 2003. I am a strong proponent of peer support services, the use of peer specialists in traditional mental health service settings, and involving mental health service users in all aspects of mental health services research and evaluation. I was trained and mentored by recovery-oriented social workers and other healthcare professionals in allied disciplines. My mentors trained me to exercise extreme caution when diagnosing others, and to systematically affirm, identify, and integrate the strengths of individuals I have the honor and privilege to work with in assessing and treating individuals. All of my mentors were strong proponents of peer support services and peer specialists.

I firmly believe that individuals with SMI can and do recover, and that peer providers play an integral role in helping people live meaningful lives in communities of their choosing. I believe and assert as an educator and clinician that individuals with SMI are more likely to move forward in their own recovery when they are provided opportunities to discover and apply their unique abilities, desires, experiences, passions, skills, and talents. In Chapter 3, I highlighted my theoretical orientation to and emphasize here my sensitivity to various cultural, economic, legal, political, and social inequalities that marginalize, oppress, and coerce people with disabilities (Devlin & Pothier, 2006). Thus, I was cognizant from the beginning of my study to write memos

throughout the research process and share my thoughts, insights, and experiences with my Chair and other trusted colleagues, including peer specialists in other states.

Prolonged engagement. Adequate engagement refers to the amount of time inquirers spend in research settings and with participants (Creswell, 2016; Creswell & Miller. 2000). As described above, the orientation period prior to initiating interviews ranged from 11 to 34 minutes. This orientation period does not account for the many phone calls, emails, and text messages that were exchanged before I met with each participant. I spent a considerable amount of time before and after interviews explaining the rationale of the study and its potential implications. Several participants acknowledged that they agreed to be interviewed only after receiving an endorsement from other HCPSs that I could be trusted. One participant recalled having attended a mental health consumer conference in 2014 where I co-presented a review of the literature on the effectiveness of peer specialists with mental health service users and providers. According to this participant and others, my past involvement and familiarity with the HCPS program was a factor in their decision to agree in participating in this study.

Almost all the interviews were over an hour. I began to receive rich, thick data within 10 minutes of most interviews as participants recognized and acknowledged my effort in understanding their perspectives and stories. Following each interview, I would debrief with each participant to ensure no one was feeling distressed or triggered by the encounter. Participants often described feeling heard and understood during this debriefing period. One of the participants stated in their interview, "I'm finding myself answering your question and then like telling myself to not go on a tangent and then I go on a tangent and I forget what the question was." I normalized this participant's concern and addressed it again at the end of the interview reassuring this participant that most conversations are circumstantial; however, their willingness

to share their honest and candid experiences and perspectives provided rich data that greatly contributed to the study.

Peer debriefing. Peer debriefing or peer examination refers to the review of the data and research processes by someone who is knowledgeable about research or the topic being explored (Creswell, 2016; Merriam & Tisdell, 2016). "A peer reviewer provides support, plays devils advocate, challenges the researchers' assumptions, pushes the researchers to the next step methodologically, and asks hard questions about methods and interpretations" (Creswell & Miller, 2000, p. 129). A colleague who is a subject matter expert in recovery and in the use of qualitative methods supported me by reviewing interview transcripts and compared her initial codes to mine. We reviewed these transcripts together and found few differences. The only differences that were found were specific to the first interview. My colleague had years of experience in conducting qualitative research using grounded theory, and I was unaccustomed to using gerunds with initial coding. Once I better understood the use of gerunds with initial coding, there were no other discrepancies. Throughout my study, my colleague reviewed other raw data and assessed whether the codes and my initial findings were plausible. We met several times a month to review my entire dataset and to debrief each interview.

Human Subjects Consideration

Under an expedited review procedure, The University of Hawaii at Manoa's Social and Behavioral Sciences Institutional Review Board approved this study (Protocol Number 2016-30195) on July 22, 2016. I reviewed the informed consent form with all participants and administered a short screening questionnaire to ensure participants understood their rights before initiating interviews. Participants were reminded throughout the interview that they may choose to not answer questions and that they may choose to terminate the interview at any time.

Participants received a $20 gift card for their participation in the study. Informed consent forms were completed online using a secure, cloud-based password-protected software program only accessible to the researcher. Names and other identifying information (e.g., year graduated from the program, names of HCPS trainers, cohort specific curriculum) were removed from transcripts and from the final report. I intentionally removed and refrain from collecting demographic data considering the small population of HCPS.

CHAPTER 4: FINDINGS

The purpose of this study was to examine the perspectives and experiences of Hawaii's mental health service users in becoming certified peer specialists and what their perspectives and experiences can possibly tell us about their recovery. Utilizing a qualitative methodology to gain in-depth understanding of Hawaii's peer providers' experiences, the following three research questions served as a guide for this study:

1. Why do Hawaii's mental health service users choose to become peer specialists?
2. What are Hawaii's peer providers' experiences following certification?
3. How did the Hawaii Certified Peer Specialist (HCPS) program impact their recovery?

In addition, I analyzed and interpreted the experiences and perspectives of participants through the lens of Rocco's (2005), Devlin and Pothier's (2006), and Hosking's (2008) conception of CDT. This chapter presents findings from the study. The chapter is organized by my first and second-level analysis.

First-Level Analysis

In this section, the experiences and perspectives of eight HCPSs were examined. An inductive approach using grounded theory identified the following four main themes that answered my three research questions: (1) prior to training and certification, the prospect of participation instilled hope of moving forward in their own recovery and helping others with similar lived experiences; (2) subsequent to training and certification, the lack of follow-up support services and few employment opportunities resulted in feelings of frustration and hopelessness; (3) ongoing systemic stigma and discrimination maintain barriers to integration; and (4) completion of the program increased their confidence, decreased their feelings of

isolation, increased their empathy towards others with mental illness, and broadened their perspectives and worldviews.

Before describing each theme and their corresponding subthemes, it is important to highlight my decision to honor my advisors' recommendations to refrain from collecting and reporting on demographic data. Four participants articulated the same concerns of potential reprisal during the recruitment period or immediately before consenting to participate in the study. For example, Participant 7 referenced the Hawaii State Department of Health's decision to immediately remove a HCPS from their position whom Participant 7 described as a "true advocate" and "voice for Hawaii's mental health consumers." Participant 7 described:

> When the state removed [name] from [their] position. I thought that was handled so badly. I still am angry about that! I was told [name] was treated really unfairly. And, you know, one thing about [name] is that they're really good about rallying people… And, I felt that, I actually don't know anything why they let [name] go, but [name] has a real connection with peers. [Name] maintained that connection.

I intentionally did not collect or report on demographic information, including employment status, given the small number of HCPSs. Further, the number of HCPSs who have maintained their credential and who are actively employed in traditional mental health service settings is not known. The Hawaii State Department of Health's Adult Mental Health Division's webpage on the HCPS program references a HCPS register; however, there are no active links to a register and no indication when the page was last updated. At the time this report was written, there was no information or process for verifying the credentials of a HCPS.

All participants self-reported having worked for and/or completed an internship as a peer specialist in a traditional mental health service setting in Hawaii. Participants graduated at different times in different cohorts since the inception of the HCPS program in 2003. Although women and men participated in this study, I intentionally use *they* and *their* as singular, gender-

neutral pronouns and refrain from using pseudonyms to prevent potential stereotyping, since names imply class, cultural, ethnic, and age-based connotations (Saunders, Kitzinger, & Kitzinger, 2015).

Theme 1

Prior to Training and Certification, the Prospect of Participation Instilled Hope of Moving Forward in their own Recovery and Helping Others with Similar Lived Experiences

All the participants offered more than one reason for applying to the HCPS program. In addition, all referenced hope as they described their motivation for applying to and completing the HCPS program. Five themes emerged that were directly related to instilling hope of moving forward in their own recovery and helping others with similar lived experiences. First, the lack of mental health consumer advocates in traditional mental health service settings motivated some participants to consider applying for and completing the program. Participants described their hope that as HCPSs, they would potentially fill a needed gap in the community. Second, participants applied to the program with the expectation that they would secure employment as peer providers. Third, participants described how others encouraged them to consider formal helping roles in the mental health field. The encouragement from others provided them with hope that they themselves could help others with similar lived experiences. Fourth, participants applied to the HCPS program with the expectation that they would learn more about mental health and about mental disorders to support themselves and others in their own recovery. Fifth, participants described a desire to help others in their own recovery from SMI.

Lack of consumer advocates in traditional mental health service settings. Participants described various ways that mental health professionals exercise control over mental health service users in traditional mental health service settings. Across participants, there was

agreement that mental health professionals speak on behalf of and make decisions for mental health service users; thus, participants described their interest and motivation in becoming mental health consumer advocates, since they observed a lack of mental health consumer advocates in traditional mental health service settings. They described their hope that as HCPSs, they would fill a perceived gap and need in the community.

Participant 2 was actively involved in mutual support groups before applying to the program and became aware, through conversations with other mental health service users in groups and through their own observations in treatment, that mental health professionals made decisions, sometimes without the consent or input of their peers, for mental health service users. Participant 2 explained that mental health professionals often prescribe interventions that are not interesting or valued by mental health service users. Participant 2 referenced their own experience working as a HCPS and confirming what they had been told by others. Participant 2 explained, "I was just told [by staff] to do WRAP [Wellness Recovery Action Planning], but they [referring to mental health service users] are not interested in WRAP… we would go out to the mall… or get out in the community and hang out." Participant 2 later explained that many mental health professionals are unfamiliar with what peer specialists do and that there is an inclination to prescribe treatment without trusting the experiential and informal support that is the hallmark of peer provider services.

Participant 6 reiterated throughout their interview that there was "a shortage of HCPSs" across the state and, as a result, there was a need for more mental health consumer advocates who understood what it was "like to live with a serious mental illness." Participant 6 described their belief that by sharing their own lived experiences, they would be able to instill hope and encouragement for others with SMI.

Participant 8 emphasized their frustration towards the mental health system in general for not honoring mental health service users' voices in outpatient mental health service settings:

> The one thing that I really did not appreciate being a consumer was, you know, was the lack of a voice. You know, there was no, it was like they [referring to behavioral health professionals] did not take you for real. They just treated you as a patient, or someone with a disability. And, so therefore, you were not considered as a whole person. And it was because you had a disability. And you know, that in itself, can anger someone, because you know, if I had a broken leg, are you going to treat me like I am not a whole person? So, here we have someone, you know, they treat the physical illness differently than they dealt with a mental health issue. And to me they are both health issues. And, I'm actually able to see these things, you know, I am able to see it. And I felt a little, you know, you become a little, I don't want to say angry, but you're not comfortable with the idea that you're being treated like that and others are being treated like that. And, and I was with certain mental health issues are unable to keep up with what, you know, you know the providers are doing… I have seen people [referencing behavioral health professionals] take advantage of people that they did not feel were on their level. And that inspired me. That is what inspired me to become a peer specialist.

Participant 8 later commented, "You know there was a lot of times that the [mental health consumers] voices' wasn't being heard in mental health….they [referring to mental health professionals] wouldn't take them seriously, and they wasn't able to articulate what their needs were."

Expectation and hope for employment. Almost all of the participants were unemployed at the time they applied to the HCPS program. Participants applied with the hope and understanding that they would secure employment as peer providers after they completed the HCPS program. Participants 1 and 2 described having conducted various searches using different Internet search engines to find employment. Neither participant knew about the HCPS program prior to conducting their Internet searches. Neither recalled the words used or search queries they entered that led them to the HCPS program or to jobs that referenced the HCPS program. Both recalled that they were interested in finding work where they could apply their experiential

knowledge and lived experience to help others move forward in their own recovery. Participant 1 explained how they found the HCPS program by chance:

> It was literally just by chance. I stumbled upon it one night. It was late at night and I was on the Internet. I was looking for job opportunities. And I just so happen to come upon this website. I guess it was, the consumer, it was for the consumer affairs office and I typed in that I was interested. I was interested in finding a job. I put in my name, my email address, my work history, and my phone number. And, it was a few months later and they called me.

Participant 2 also discovered the HCPS program by chance. They described having gone online and discovering that most peer provider positions in Hawaii referenced the HCPS credential in the job description's minimum requirements:

> I just wanted to get a job. I wanted to start working. Really. I wanted to understand more about mental health problems and I thought when I was looking for jobs on Craigslist, and a lot of the agencies, it said that you needed a peer, to be certified, yeah. That is why I applied. I like one job.

Participants 3 and 5 learned about the program from friends who had applied to the HCPS program. Their friends explained to them that they had been told that mental health service users who successfully completed the program would become employed. Both were curious and applied.

Participant 6 learned about the HCPS program from their case manager. The participant knew nothing about the HCPS program and reported, "I thought that being a HCPS was going to be a good opportunity to open my options and career." According to this participant, their case manager was familiar with and endorsed the use of peer specialists and the HCPS program.

Participant 7 learned about the HCPS program from staff at an intensive mental health outpatient partial hospitalization day program. Participant 7 was under the impression that they could secure meaningful work where they could potentially help others early in their recovery. Staff from the intensive mental health outpatient day program encouraged Participant 7 to apply.

Encouragement from others to consider formal helping role in mental health system. Participants identified various people in different roles who encouraged them to consider employment where they could help others with similar life experiences. Participants emphasized that this encouragement provided to them by their supporters was influential in their decision to apply for and complete the HCPS program. It offered them hope that they could help others.

As highlighted above, Participant 6 learned about the HCPS program from their case manager. Their case manager educated them about the program and explained how they would be able to support others in their own recovery.

Participant 2 was also encouraged by their former case manager and their psychiatrist to consider a career in mental health. Years after graduating from their outpatient mental health treatment program, Participant 2 recalled an encounter they had with their former case manager in the community where the case manger recognized and acknowledged the participant was thriving in their recovery. Participant 2 recognized, "I was like doing so good in life that I should go help in the mental health field." They also recalled at their last psychiatric appointment where their doctor ended the encounter with, "I'll see you in the field." At the time, Participant 2 was confused by the psychiatrist's statement, but attributes these two encounters, and the encouragement from other mental health service users, to their decision of becoming a peer provider. Participant 2 was also encouraged by others in recovery to consider employment where they could help others with similar life experiences:

> I have been through so much. And I remember, once I was in recovery, I was in [support] groups, one of the people in my group, she always telling me, you need go back to school and get your degree cause you can help so much people. You have so much information. So, she kind of inspired me also. Other people in the support group would always encourage me too. That's why I applied to become one peer.

As identified earlier, other participants learned about the HCPS program from other mental health service users who had applied to the program. Participant 3 explained:

> A close friend of mine was diagnosed with a mental illness earlier on and she did not tell me, and I had not heard from her in a long time. We crossed paths and she had told me in confidence that she was going to participate in the peer specialist program. That sounded interesting. I asked her what that was like. She gave me information. She told me whom to contact. I spoke with the office of consumer affairs…. [they] explained the recruitment process, how to apply, what was involved in the program.

A friend of participant 5 was accepted into the HCPS program and also encouraged them to apply. Participant 5 recalled the risk they took enrolling in the training without knowing anything about it:

> A friend of mine was doing the training. And, she encouraged me to take the training…She just told me. She told me. Come check out this training. I think you are going to like it. Also, my friend was already in the system, yeah. With that, she encouraged me to take the training. I had no clue. I did not know what I was walking into. She kind of told me you know, like, you are going to like it. You are going to learn more stuff about mental health. She said, just come. And I said OK. That is how I started the training.

Participants 3 and 5 were thankful to their friends for having identified and encouraging them to apply. They suggested that their friend's endorsement and encouragement were influential in their decision to becoming HCPSs.

Expectation of learning more about mental health. Participants applied to the HCPS program with the hope and expectation that they would learn more about mental health and mental disorders in general, the mental health system, and effective strategies to help themselves and others as they move forward in their own recovery. Participant 4 was actively involved in facilitating peer-run support groups before having applied to the program and recognized the need for more education on mental health to better support themselves and other mental health consumers. Participant 4 explained:

> I thought I should get all the training that I could, cause I was in mental health, for myself. I needed to know what it was. What I didn't know… I wanted to get a better understanding of mental health and to learn everything that I possibly could about mental health. The more you know the better you get. You are able to better understand it…. I thought I would learn something that I could substantially use when working with other people.

Participant 4 maintained their frustration that other mental health service users were potentially motivated to apply to the HCPS program to learn more about themselves. Participant 4 asserted, "A lot of people, I think, enroll in the program to learn more about their mental illness. To help [only] them[selves] in their own recovery. That is not the right attitude. The right attitude is that they want to help others." Participant 4 later explained their hope that the attitude of future candidates would change to recognize the value and importance of mental health service users working together to transform the system.

Participant 5 was disconnected from the mental health service system and only learned about it through participation in peer-run, mutual support groups. As described earlier, Participant 5 learned about the HCPS program from a friend and recognized the potential value of learning more about mental health and about the mental health system with the intention of helping others. Participant 5 recalled their experience discovering resources and supports in the community and how the training would support them with identifying and sharing resources with other peers who were not connected to traditional mental health services:

> I started, you know, going to … meetings. I kept going back. And, I started, you know, like connecting with other peers. And like, I started to find out about mental health, because I never knew about mental health… I then learned about the community mental health centers. I did not even know they were there. I never knew there were case managers or social workers. I never knew about the system. I did not know there were places to go for mental health issues. I found out everything from going to meetings, and connecting with people there. I found out all about the resources in the community for people with mental illnesses… I wanted to learn more about mental health and the resources we have here throughout the community and State. Um, you know, like yeah. I wanted to learn about my own mental health too.

Participant 6 expected that the training would help support them in providing mutual support to others. Participant 6 stated, "One of the reasons [I applied] was to better understand my coping skills and also to help other people understand their illness coming from somebody who has been through it and trying to be successful while recovering from my own mental illness."

Participant 8 explained the training would help them support others by learning more about traditional mental health treatment. Participant 8 maintained throughout their interview that mental health professionals use medical jargon and terminology that is not easily understood and could potentially trigger mental health service users to experience increased symptoms:

> They would speak in a medical jargon to the consumer and the consumer could not understand that. And to me that would trigger some of their symptoms because they would get frustrated and stressed. And not being able to relay over to them what their you know, their underlying issue was. And, I kept watching that… Yeah, it was more so, what I would consider the medical model. You know, more so, do as I say because I am the doctor and I know. And you're the patient. And, I know better for you! Which to me was not conducive, you know, resolving the consumer's interest.

Participant 8 continued by pointing out the need for peer providers to learn more about mental health and the system in order to help mental health service users move forward in their own recovery. They suggested that HCPSs could translate and advocate for others. Participant 8 explained, "The more knowledge I can get the more that I can share… if I can get this knowledge and be able to explain it to people, you know, in a common language, it will help them also." Participant 2 simply referenced their desire to learn more about mental health when they were looking online for employment as a peer provider.

Desire to help others in their own recovery. Participants described having made significant progress in their own recovery where they wanted to help others with serious mental illnesses. Participants emphasized their hope that once certified, they would help others move

forward in their own recovery. Participant 1 emphasized, "Everyone has a moment in time, a time in their recovery, where they say this is enough! I have had enough of myself, and now I am going to move on" and help others. Participant 1 described in detail how they aspired to have a meaningful life and what transpired immediately before they made the choice to help others. Participant 1 explained:

> Enough zoning out on medications. Enough, just staying here and being psychotic, watching TV, and sleeping all day. You know? And I came to that point too. You know? I am over medicated. I need to get going. And so I started walking. I stopped taking all the medicines that the doctor had put me on… I stopped hallucinating. All the hallucinations stopped. You know? And I got better. I started losing weight. Because all the exercise. My system. You know. I got healthy. I started going, I started getting out, I started to eat better. My mind, you know, it was clear again. I could read again. I was happy.

Participant 3 explained their own reservations working with and trusting mental health professionals early in their recovery. They believed that by assuming a new role as a peer provider, they would be able to help others with serious mental illnesses who may be reluctant to engage in traditional mental health services:

> It's not the same when talking to a peer. They've been in your shoes. They don't have the same exact experience but it's similar. They know what its like. They have similar struggles. The same lived experiences. I wanted to offer that to somebody else. I did not want them to feel alone like I did.

Participant 3 suggested that adults with SMI not connected to services were more likely to use mental health services if they also received services from a peer provider.

Participant 6 identified various people in their recovery who had helped them move forward in their own recovery. Participant 6 described the evolution of their recovery and the importance of finding supporters. Participant 6 acknowledged, "I just wanted to give back to all the people that helped me get to this point in my life, especially those who helped me with my mental illness."

Participant 7 emphasized the importance and value of others offering them hope and encouragement, especially during difficult times in their own recovery. Participant 7 explained:

> The way somebody responds to another human being is so important! You know, whether you are in a mental setting or just an ordinary setting where you are just talking with someone over coffee. That, that's the thing! You know, it is so powerful, how one human being reacts to another. And I know when I was [not well], I was really helped by people who could, even though I was [not well], people responded to me in a positive manner. You know, instead of just saying, just the same old thing, I had this [supporter] and I would contact [them] everyday… they never told me, don't be silly, [they] really talked with me. [They] really listened.

Participant 7 applied with the intention of learning how to listen to others to help them move forward in their own recovery.

Participant 8 maintained that their motivation for applying to and completing the training demonstrated to themself, to mental health professionals, and to other mental health service users that adults with SMI who receive mental health services have the capacity to complete a rigorous training program. Participant 8 explained:

> I wanted to demonstrate to the mental health community that there were, you know, there was consumers who were able to follow these, you know, these rules, everything that, that they are putting out there, for us to be able to get this, you know, this certificate… I wanted to offer, you know, I wanted to show that there are consumers that, who can follow the rules, and can deal with the training and be able to have a voice to be able to help, you know, other consumers. And be able to show them, you know, that they can do it also.

Participant 8 emphasized that completion of the program was significant and symbolic in participants moving forward in their own recovery. Participant 8 stated that completion of the program would offer hope to other service users that they too could complete a rigorous program.

Theme 2

Subsequent to Training and Certification, the Lack of Follow-up Support Services and Few Employment Opportunities Resulted in Feelings of Frustration and Hopelessness

Participants attributed the lack of follow-up support services and few employment opportunities to feelings of frustration and hopelessness. Participants stated that few mental health service organizations in Hawaii employed peer specialists. Further, participants were unclear whether there were resources outside the State Mental Health Authority to help them with securing and maintaining employment as peer providers. Three themes emerged from participants describing their frustration with the lack of follow-up and job prospects. First, participants described feeling misled and frustrated about employment opportunities as peer providers. Second, participants described their disappointment with the lack of ongoing support, formal communication, and continuing education opportunities for peer providers. Third, participants expressed sadness and concern for mental health service users who participated in, but separated from the program before receiving their certification (i.e., "the forgotten").

Feeling misled about employment opportunities. Almost all the participants stated that trainers and others affiliated with the HCPS program articulated a clear expectation that all participants were responsible for securing competitive employment as peer providers following their certification. Several participants also referenced the attestation form in the HCPS application packet that confirmed applicants would seek out competitive employment as peer providers following graduation.

The emphasis and expectation that mental health service users who completed the HCPS program would seek out and secure competitive employment as a HCPS created an expectation and assumption that employment opportunities existed in the community; however, most came to

realize that few opportunities were available, especially in traditional mental health service settings. In addition, participants reiterated throughout their interview that few HCPSs were currently employed as peer providers in traditional mental health service settings. Participants 1 and 2 confirmed that most members of their cohort were not employed as HCPSs and that the majority of their classmates remained unemployed.

Participant 1 confirmed that their cohort was told from the beginning of their training that there were employment opportunities for peer specialists in the community and that the expectation was for them to apply for these jobs and to work. Yet, their cohort heard rumors that few opportunities existed in the community and there were concerns about potential prospects. Participant 1 revealed:

> You know, my expectations, everybody said well, upon graduation, everybody said you know its not really likely that we are probably going to have jobs, but let's just hope that they will find us jobs, or we'll get jobs. You know, that was the reality. Everybody kind of knew that.

Despite "murmuring among my peers," Participant 1 acknowledged that they remained hopeful and optimistic regarding potential job prospects:

> I did not bother listening, you know. Because, I am more hopeful about things, you know? I feel like well, that's them, you know? That does not necessarily mean me. You know? I still yet felt like I had this training under my belt. And I could go work. I knew I could find employment… I knew I could find employment no matter what.

Participant 7 admitted to having low expectations for employment following their certification, but remained hopeful that prospects would later become available. Participant 7 explained, "I was hoping that I would be able to get a job. But, I did not have a clear picture of how many jobs were available, so I did not have any really high expectations."

Participants 2 and 5 also stated that they too were told that the expectation for all HCPS graduates was to work full-time as peer providers following certification. Participant 2 remarked

feeling discouraged and hopeless when asked about their life following certification. Participant 2 responded, "Well, like I was hoping that it would be like better, you know? I am certified and still don't have the job that I want." Participant 5 asserted,

> Honestly, I don't know why they have the program. I don't know why they spend so much money on the training. Because there are no positions. Yeah, because of when I went, they kind of pushed that. You know, work… Yeah, you know, you get so scared. They are saying we are going to get jobs, and so, then now we are panicking, and like, and then you get certified, you kind of keep in touch with everybody, and stuff like that, and then you learn there is not too much positions, you know, there should be more, but, there are so much people telling me, eh… there is no jobs!

Participants 7 and 8 also stated that most HCPSs in their cohorts were not working. However, both suggested that peer providers should consider the training as a starting point for their careers. Participant 7 asked that their comments regarding the low number of employed HCPSs remain off-record. Participant 7 articulated concerns that their comments regarding the low number of employed HCPSs would negatively reflect the program and its role in empowering mental health service users. Instead, Participant 7 saw the HCPS training and credentialing program as a starting point and suggested for HCPSs to ask themselves:

> Is this something that you want to do for a little while, or are you interested in being in the mental health profession. Do you want to be a case manager or a therapist? Just, not to think that this is going to be a dead-end job. Because, I think, for the person its important to have this be part of this general long-term plan.

Participant 8 also emphasized the training and certification as being the starting point. Participant 8 explained,

> Don't stop there. It [referring to the HCPS program] shows you that you can do a lot more, I think this training shows that you can move on. It is a first step. But I did not feel that way when I first did it. I thought that this was going to be like, alright, this is going to open the door, yeah this is it! And then I got out and learned, and I was like wait a minute… where is the support for the peers and where's the jobs?"

Participant 8 attributed the low number of actively employed HCPSs to the Department of Health not being held responsible or accountable to an external group or accreditation body. Participant

8 explained, "I think this [referring to the HCPS program] was some sort of mandate or something that they had to throw in there that they show that they are working with consumers. Just to show that, and once they did that, well look, we don't have to do anything more."

Disappointed with ongoing support, formal communication, and continuing education. Participants described their frustration that they received no support, formal communication, or continuing education through the Hawaii State Department of Health. Most participants reported that they were told directly by various representatives from the State of Hawaii that they would receive ongoing support following certification. In addition, participants described their frustrations for not having access to opportunities that would address the unique challenges peer providers experience working in traditional mental health service settings. Participant 8 emphasized their frustration with the system for not having developed an infrastructure and support system for peer specialists:

> There is no support for a peer specialist, I don't know if that was done intentionally for us to not feel as strong as we did coming into the program or into our certification. I don't know. I tend to think, I don't want to be a conspiracy theorist on, you know, these situations; however, I don't see where the support is... there is no real support system for you after you become certified. There is no group of people that are there for you in case something is not right. Or, to speak for you and why would you need someone to speak for you if you are certified.

Participant 2 also expected ongoing supports would be provided by the State of Hawaii. Participant 2 recalled that representatives from the State assured participants that they would be there to support them throughout the employment continuum. Participant 2 recalled,

> I expected like, from what I heard, I remember the trainer saying that we're going to help you get a job and if it does not work out we are still going to help you. Ah, work with you. So, that you can get a peer specialist job and they never did call. You know? Or follow-up.

Participants 2, 7, and 8 expected the Hawaii State Department of Health would take the lead with establishing peer-run support groups for HCPSs in the community; however, at the time participants were interviewed for this study, no support groups for HCPSs had been established.

Participant 4 emphasized that few HCPSs were employed in traditional mental health service settings, and attributed this to the State's role in supporting HCPSs and the organizations that employ them. Participant 4 suggested,

> They [referring to the HCPS] need someone to check-in with them to see that they are doing well. If we really want the program to improve, you know lots of agencies just have the peers doing clerical work, filing, they could get more involved to support the peer and the agencies.

Participant 4 suggested that ongoing monitoring was necessary for peer providers and agencies to succeed with integration efforts.

Participant 5 described the need for ongoing support and encouragement from other peer providers, especially after HCPSs are certified and considering employment. Participant 5 described themselves feeling lost following certification. Participant 5 explained,

> OK, you take this training and you are getting to get certified. And you going to get a job? And you are kind of like left there. And, like OK. You are on your own. We do have trainings, but when you come from nothing and you start your life again, its like everything is moving at a slow pace, it's not like you pick it up real quick.

Participants also noted that few opportunities were made available to HCPSs for continuing education. Several participants described their expectation that the Department of Health would take an active role in providing continuing education opportunities for peer specialists, considering the relative small number of peer specialists who have been trained and credentialed. Participant 7 referenced the Hawaii State Department of Health's Alcohol and Drug Abuse Division for providing continuing education opportunities to certified substance abuse

counselors, and assumed the Department of Health would do the same for peer specialists. Participant 7 commented:

> I know that we do look for trainings to get the required number of CEUs [continuing education units] to maintain our certification. But, it's been so nebulous. And its, I know that the AMHD [Adult Mental Health Division] did have something awhile back, but they came, they came out with the announcement so last minute and then by then, other people have plans... I mean, just simple things, like keeping up with all the governmental changes in mental health, unless we individually take it upon ourselves to read or follow the news, it's, even changes within our own legislature.

Participants described that they received little to no information on changes within the HCPS program or information that would impact them as HCPS. Several attributed the lack of communication to changes in staffing and leadership. Others attributed the lack of communication to inadequate resources and poor planning. Participant 3 described their concern not knowing whom to contact for maintaining their credential:

> They tell you, make sure that you obtain x amount of credits, I think its like 14 or 16 credits per year, and you are suppose to submit them… And its like, so who do I give my re-certifcation too? Where do I submit my continuing education? Like where does this go? Do I still submit it to AMHD and hope that somebody will open it? Do I fax it over and hopefully somebody takes it and then gives it to the proper department or whatever… I don't know what to do now? I am trying to stay honest… I don't know what to do now. You know, I am just going to keep on going to all these trainings and accumulating all this credit and take inventory of everything.

Participant 3 explained their concern that some external entity would audit them and potentially revoke their credential. Participant 3 expressed:

> I was afraid of being audited. They kept on engraving in our brains throughout the entire peer specialist training – you have to do this! You have to do that! You have to do everything to the letter. There is no, you know, no shortcuts. Do it this way. And, so I am doing it but there is nobody left to report to.

Feeling concerned and sad for the forgotten. Participant 1 asked whether I would interview "the forgotten." This in-vivo code specifically referred to individuals who were accepted into and participated in the program in various degrees, but separated before they

received certification. All participants verified that individuals from their cohorts separated from the program. According to participants, most failed the oral or written examination or, in some cases, "went ballistic" (Participant 4) or "decompensated" (Participant 8) in the training. Participants suggested that some people experienced debilitating symptoms that made it difficult for them to complete coursework. Others suggested that the training itself was very stressful and presented different triggers. Participants identified trainees by name who separated from the program for various reasons, and they offered their best estimate on the number of their classmates who became certified. Several participants became noticeably uncomfortable when describing "the forgotten." Most expressed concern that there were no known follow-up supports for the forgotten. I agreed not to identify the specific number of mental health consumers from each cohort, since this number would potentially identify the participant. Participants offered different explanations to account for their classmates separating from the program.

Endurance training. Participants were critical of the program's format and duration. All agreed that the format and duration were partly responsible for students separating from the program. Participants 4 and 8, both from different cohorts, described the HCPS training as "endurance training." Participants described the challenge for anyone, and in particular, people in recovery from a SMI to participate in a two-week, all-day training where trainers primarily read from a workbook. Participant 1 commented:

> The trainers just read straight from the book. Yeah, a large book. It was a large folder. Just read all the way thru. All [trainer name] did was read, read, read, read. Next page - read. Next page - read. And there were no exercises. And sometimes they would get tired of reading and they would ask for a reader. It at least it kept everyone up.

Participants described the training as "really slow" (Participant 1) and that they felt "discouraged" (Participant 4), "irritated" (Participant 2), and "bored" (Participants 1, 2, 4). Participant 8

suggested that the organization and format of the training specifically "weeds you out" and that if you "cannot keep focus, you're out!" Participant 8 highlighted:

> Look at the ratio of how many people are in the class at the beginning and how many people actually passed the class… I was shocked about that myself. What? We started off with like […] and after the first day there was like […] and then when the 2 weeks were over […] dropped out and then we took the test, and it was like only […] that became certified and that was that.

Participant 4 emphasized:

> I don't think it should be as long as it is. Too many days! It's really difficult for consumers… Some people, what worried me, was that some people went ballistic. They relapsed. They decompensated in the training. Other people were just freaked out about the test.

Participants commented on their classmates' use of psychotherapeutic medications for their own recovery and suggested that side effects of these medications made it even more difficult to sit for long periods of time and to maintain their concentration. Peers were described as "zoning out" (Participant 2) and having "difficulty paying attention" (Participant 1).

Distressing testing. Almost all the participants described the oral and written examinations as distressing. Participants described their frustration that students were tested on materials not covered or reviewed in the classroom. Participant 3 commented:

> The written test, it wasn't too bad. It's open book, but it's based on your notes. How good you made notes. Wrote notes. And because you are not going to find the answers in the book, but the reasons they have it open book because you are allowed to look thru your notes. You were allowed to look at your notes and the peer specialist manual…. The questions they would ask would not be in the manual, but in our notes. I mean even though its open book, it really does not help you much unless you took notes… So, for those who missed some classes and just thought 'I am just going to wing it,' they did not do well.

Others explained that the trainers would periodically highlight specific sections in the manual that would potentially be on the exam, and that some students failed the exam because of their choice not to pay attention or take notes. Participant 1 explained,

> So, when we took the written test, it was difficult… unless you were really paying attention and taking notes… If you did not do that or underline parts where [trainer's name] said pay attention, here, this is going to be on the test… You missed it. And those people missed it. They did not pass the test.

Participants 4 and 8 suggested that grading of oral and written examinations were subjective and the ability for participants to take notes or reference specific materials was irrelevant.

All participants agreed that trainers emphasized the importance of the oral and written examinations, and that passing became a central theme throughout the training. Participant 6 explained:

> We all shared one common goal to graduate from the program. We were all there for one reason… [We were] all united for one common goal. The goal was to graduate from the program.

Participant 4 described their frustration that trainers emphasized testing over application of skills in helping other mental health consumers move forward in their own recovery:

> The thing is, some of the best people are those that score low on the test. Some of the dumbest people score well and do well on tests. They are not prepared to become peers. We should all help each other. We need to stop being selfish; it's half attitude and half comprehension. So many don't believe they are going to pass. They are so concerned about passing.

Admission criteria. Participants suggested that some of "the forgotten" should never have been admitted into the program. Several participants suggested that the selection of mental health consumers was highly subjective and that the state assumed too much control over the selection process. Several participants suggested that peer specialists not attached to the Office of Consumer Affairs be responsible for selecting mental health consumers to participate in the program. Participant 4 was critical of the selection process and argued:

> What about people who work? You're automatically filtering out and removing people who are less acute. They have jobs. Eight hours a day for 2 weeks? That just tells us that if you are not working, you don't have a job, you have nothing else in your life, and nothing to do, and you can sit for 8 hours you qualify - that's not right! That's not right.

Participant 4 emphasized their frustration throughout their interview that the program continues to focus its efforts on activating the unemployed and choosing to not make any changes to its format and schedule. Further, many of the participants expressed serious concern and sadness for the forgotten, and questioned whether those who separated from the program received any follow-up supports.

Theme 3

Ongoing Systemic Stigma and Discrimination Maintain Barrier to Integration

Participants described various ways that systemic stigma and discrimination hinder the integration of peer specialists in traditional mental health service settings. Four themes emerged that were related to barriers to integration. First, participants described their own ambivalence about competitive employment in general. As described below, their ambivalence was attributed to poor compensation of peer providers and concerns regarding the loss of entitlements. Second, participants described a perceived hierarchy across peer provider types. Third, participants stated that traditional mental health service settings in Hawaii were trauma-inducing work environments that were not adequately prepared for successfully employing or integrating peer providers. Lastly, participants described disabling barriers with having a specific tile that labeled them as peer specialists.

Feeling ambivalent about employment. Participants described feeling ambivalent about employment following certification. As highlighted earlier, almost all the participants were not employed at the time they were accepted into the program, and the expectation of working following certification was abrupt. Participant 6 commented on the immediate change they experienced from being unemployed for years to being competitively employed. Participant 6

stated, "Like I said, it opened doors for me. Not realizing how fast the doors has opened for my career. It was like all of a sudden, am I ready to start my career? It's a drastic change."

Participant 2 discussed compensation as a key factor for their ambivalence for securing employment as a HCPS. Participant 2 noted, "It's just that the pay that they offer certified peer specialists is so low that its like for me… it's not even worth it!" Participant 2 also remarked on the potential that traditional mental health service settings take advantage of HCPSs by having them bill Medicaid. Participant 2 explained,

> Yeah, we can bill like $60 for half an hour or something like that. Yeah, so that caught my, so that opened my interest, the money. And then, in reality, I cannot get that money because the agency going get all that money and I am only going get a portion of it. So why can't they offer it as individuals' cause you know the agencies get all the money already, you know? And for me, knowing that I can make so much more money and it's going to go to one agency, its like, that sucks!

Participant 2 and others could not recall whether the trainers or State provided any information on beginning or median salaries for HCPSs.

Participants 3 and 5 were told that the expectation for participating in the program is that they work as peer specialists. However, both participants reflected on their own readiness to work and the importance of self-care to prevent possible vicarious or secondary trauma. Participant 3 noted:

> I did not get a job right away even thought they tell you when you are done with the training if you pass that they would like you to start working right away... I did not get a job right away even though I passed. I wanted to first of all I wanted to be ok with myself. I wanted to work on my own recovery and be ok working with other peers knowing that there would be a possibility that I may be re-traumatized… I wanted to just make myself mentally and physically OK first.

Participant 5 explained they had ben unemployed for a long period of time, and that there was ambivalence of going back to work. Participant 5 reported:

> Well, I know that, you know they talked about getting jobs and getting people to work, which was kind of scary for me too, because I did not work. Not really. I was kind of like,

> you know, just following along with this wave. You know, OK, meeting people, getting involved with mental health, going to all these trainings and different conferences. Yeah, I was just following… following everybody around.

Participants 5 and 7 discussed the ambivalence they and other HCPSs encountered when deciding how competitive employment would impact their entitlements. Participant 5 noted that they were employed in an agency that supported them as they navigated Social Security and other entitlements; yet, the participant noted that this is the exception and not the expectation in traditional mental health service settings. Participant 5 explained,

> It is so sad because people are like so eager, you know they want to work, and then they are like, oh, but my social security is going to, you know, be involved. You know, it might get cut off. That part comes up, but they want to work, because that is what happened to me. I had SSI. I too was like, I don't know if I like work, because you know this and that, so I moved in slowly, you know, and I was fortunate, to have … being the first place when I worked. They were like, 'oh don't worry about it, we can take care of this, we know how to break this down for you,' so I was fortunate. But, if you are not coming across people like that, and you are working anywhere, within the system, anywhere. So many people are so worried about getting cut off. They are really scared. You know, really scared. They want to work, but how does that affect their benefits. Even that, everybody is not able to take the time to go over that, unless you have a good case manager, or you work, so that's why, I think they need to know, that is why I think, with the training, that should be important part of the training, you know.

Participant 5 clarified that representatives from the Social Security Administration attended the HCPS training, and they acknowledged the State for incorporating a discussion on entitlements into the training. However, Participant 5 pointed out that they and others were concerned and had reservations to discuss their financial situation with these representatives. Participant 5 explained,

> I know that they do have the social security people come in. But, still when you are like fresh off the boat, and you go to these classes, you know, you kind of just sit there, you know, you kind of nervous, you meeting all these people, you're saying hi, but you get so much fear inside and you know, that there are these persons over there you suppose to talk to, but you know, it's kind of like, you know, you need the courage to kind of stand up and go talk a stranger about this personal, you know, your personnel finances. I don't know them. I am kind of scared to talk to them. I don't want to get cut off from my social security. Because that is all I know. That is all I have, you know?

Hierarchy across peer provider types. Participants identified peer specialists, peer coaches, and peer mentors as peer providers in Hawaii. Participants clarified that peer coaches and peer mentors are also mental health service users who worked in traditional mental health service settings, but they offered very different conceptualizations when comparing these peer provider types.

Participant 1 explained that trainers differentiated peer specialists as being advanced paraprofessionals. Participant 1 revealed that trainers emphasized in their training:

> Peer specialists were getting more education, so we were a step above. We were better than the others [referring to peer coaches and peer mentors]. What made us better was that the education we were getting. And, you know the positions we were going to get. We had it in our heads that we were better, you know? But, its not true!

Participant 1 explained that they were not alone in their belief there was a difference between peer specialists, peer coaches, and peer mentors. They believed that their experiences as a HCPS in different roles helped them to see that peer providers, regardless of title, offered the same resources and supports. Participant 1 concluded,

> And I found that true for other peer specialists. It was not just me. It was other cohorts that I talked to. They felt the same way. And it was after, you know, what we are, we the same as coaches? You know because in, if you look at other kind of jobs, you know there are peer specialist jobs. Their peer specialists have to do the same thing that a peer coach does. You know? They have to, and it's more like, it's just helping somebody with their recovery. You are going to have to coach people into, you know, helping them to get ready. You are going to coach them. You are going to help them with their recovery. What is wrong with that? That's part of it. That's part of your job. You know? I can't see anything wrong with that. It's wonderful. You know. Yeah, it's just this thing that was planted in our head.

Participants 4 and 7 asserted that peer coaches and peer mentors had not received specialized training to become peer specialists. Participant 7 remarked, "my impression is that a peer coach is, may not have had as much training as the peer specialist, and it's a more general support." Participant 4 explained,

> Peer coaches, from what I gather, they just help with basic life skills, how to get on the bus. Peer specialists, I believe, work with treatment teams at agencies and they are supposed to be involved in treatment of people with mental illness. They are supposed to work with case managers.

Participant 1 recalled a conversation earlier in their career where they were questioned by their supervisor when they were tasked to accompany someone to and from their medical appointments using public transportation. Participant 1 explained that they erroneously believed the task was more appropriate or suitable for a peer coach or peer mentor. Participant 1 felt frustrated and confused questioning why the trainers would dedicate time to creating a false hierarchy among peer provider types.

Participant 2 learned that peer coaches received higher compensation than peer specialists. As highlighted earlier, Participant 2 described their frustration with compensation and highlighted the difference in pay between the two provider types:

> And the peer coaches get paid more than the peer specialists. Peer specialists get paid [X] dollars, peer coaches get paid [X]. And we got certified. I only know because [I asked a] peer coach… So, I ask her, you one Hawaii certified peer specialist? And she said no… And then I asked her how did she get one job. And she tells me, I just applied.

Unlike others, Participant 3 stated that they were told that peer coaches were advanced HCPSs. Peer coaches, according to Participant 3, were able to engage mental health consumers using more intensive supports and resources, including the use of their own personal automobile to provide transportation for mental health consumers to and from various health and social service appointments. Participant 3 explained:

> I was informed, in order to become a peer coach, you had to be a peer specialist for a minimum of 2 years… you have to be a peer specialist first and then you can be promoted to a peer coach. And the difference between a peer coach and peer specialist is that peer specialist focuses on WRAP mainly. Right? And social skills. However, a peer coach, and then with the peer specialist, they can meet out in the community or the office. Peer coach is always in the community, hardly ever in the office… They are always out in the community. And they have to… transport clients to and from their appointments…

> So they will tell the peer coach to go over and make sure that person goes to their appointment and make sure they make it back home.

Traditional mental health service settings are trauma-inducing work environments. Most participants agreed that traditional mental health service settings were trauma-inducing work environments and that none were "trauma-informed." Participants who referenced the concept of a trauma-informed work environment were asked to explain how they conceptualized trauma-informed work settings. Most suggested that mental health service users and peer providers employed in these settings should feel safe and secure in settings that support individuals in their own recovery from SMI. Participant 1, in a follow-up interview, suggested that trauma-informed work environments recognize the high prevalence of trauma histories among adults with SMI and that the system itself was also responsible for traumatizing mental health service users. Participant 1 also suggested that a clear example of a trauma-informed system of care was the use of client-centered, recovery-oriented language when describing mental health service users. Participant 1 stated, "you know, I would never want to be talked about by others on my team. They have no respect, you know, I got so angry when I listened to them. They don't know!"

Participants agreed that most mental health service users, including many in their own cohorts, had complex trauma histories. Further, they described that traditional mental health service settings and their supervisors were not equipped to successfully support HCPSs as employees. Many of the participants referenced the concept of triggers (internal or external stimuli that precipitates distressing symptoms, signs, or reactions) and identified specific triggers in the traditional mental health service settings that were not well managed or could have been prevented.

Participants identified traumatic situations and other triggers that led themselves or their peers to separate from their employers. Participant 5 highlighted:

> I have seen other people [referring to peer specialists] like just burn out or just decomp. Decomp! Like right in front of my eyes, you know, and I'm like oh my god. I have seen myself come to on several occasions and when like what I really need to do, you know, pick up some tools I learned along the way and get more.

Participant 2 described a situation where one of their colleagues separated from their work setting because of the "dysfunctional" multidisciplinary behavioral health treatment team. Participant 2 described the setting and team as "disorganized and reactive." Participant 2 explained, "They are so disorganized and its like, if you cannot roll with it, then its like you are going to have a breakdown. And one of my [coworkers] had to take a mental health break" from the employer and never returned. In a follow-up discussion with Participant 2, they described, in confidence, specific situations and encounters they had with their supervisor and colleagues that were discriminatory and triggered them to question their worth as a HCPS.

Self-care and boundaries. Participants described the unique position they assume as HCPSs in agencies that may have little to no experience working with and honoring the unique contributions of peer specialists to mental health treatment teams. Participants described in great length the various strategies they used to manage vicarious or secondary trauma. Almost all agreed and strongly endorsed the use of self-care and the importance of setting personal and professional boundaries. Participant 5 described the need for HCPSs to maintain a commitment to themselves and others, including their professional colleagues, for self-care. Further, they described the importance and need for maintaining personal and professional boundaries. Participant 5 described listening to the stories of other mental health consumers as "looking into a mirror" and having the potential to "really lose yourself," recognizing the similarities in stories and experiences. They described themselves as having high emotional intelligence and empathy

for others. According to them, they believe this strength also increases the likelihood and risk that they put themselves and others at risk for potential harm. Participant 5 noted, "I am feeling what they are feeling. I can truly understand what they are feeling, but I have to take care of myself too. I have to step back and breathe when it gets overwhelming." Participant 5 explained how self-care and boundary settings prevents them from being triggered and prevents the real potential of harming themselves and their clients. Participant 5 explained:

> When working with other peers, you listen to them, what is going on with them, it sometimes feels like looking into the mirror, you know. I can really understand what you are going through… I know it's hard, when I lived it, I can easily relate to that. I know how they feel. I totally understand what they are going through… I have to be careful… you have to set boundaries… you got to be kind of strong because if you, you know like, get too much involved with what they're going through, you kind of lose yourself too. You know what I mean? You lose yourself because you are so involved with, you know, a certain amount of people and you just get overwhelmed and really start to lose yourself. So, you got to be, you know, kind of strong, but know when, you know, you need to set boundaries… And you know recognize, just recognize, when you are having a hard time and to step back and breathe. You need this for yourself.

Participant 7 also described the reality of vicarious trauma that HCPSs experience and asserted that their recovery does not make them immune from being impacted to the suffering and pain of other mental health consumers. Participant 7 reiterated the importance of self-care. They described their expectation that their colleagues would recognize and honor their recommendations as equal partners in delivering care to mental health consumers. However, Participant 7 attributed that high turnover and the limited experience of most case managers and other behavioral health professionals working with HCPSs may lead to agency personnel minimizing the role and contributions of peer specialists. They emphasized that most agencies were not accustomed to employing HCPSs and that peers need to be mindful not to over exert themselves in order to prove themselves as contributory members of the treatment team. Participant 7 suggested:

> I guess, in these kinds of settings, mental health settings, I think its best for the peer specialist just to, not try to do everything, but just be there, take care of yourself, be sure you are doing your self-care. Some of these situations may be traumatic for you too. Seeing and listening these peoples lives and what happened to them. It can, it can be very difficult.

Participant 7 encouraged other HCPSs and mental health consumers considering becoming a peer specialist to not "take things personally" and to recognize the limited experience many mental heath professionals and other health care professionals have in the community directly working with HCPS. Participant 7 commented:

> "Don't take things personally. I think it is a little different now, the work setting are more used to having peer specialists... I unfortunately took a few of the things personally. And my feelings got hurt. And I felt that they did not value my input. And because I was so used to being a contributing member, my feelings got hurt."

Participant 3 remarked on the importance of coping with and addressing secondary trauma. Participant 3 suggested that HCPSs must "learn how to cope with [it] because you know, knowing that we are also suffering from mental illness, even though we are in recovery, we are meeting with other peers and still can get traumatized!" Later in their interview, Participant 3 revealed that vicarious or secondary trauma is expected and that mental health consumers choosing to become HCPSs should be aware of this before applying to the program. Participant 3 maintained,

> Realize that when you go into this type of work, it's not about you anymore. It's about the person you are trying to help! So, expect to be re-traumatized, expect to be uncomfortable – it comes with the job. But, be ok with it, don't, it's like don't start something that you cant finish.

Learning who to trust. Participants emphasized the importance of carefully selecting whom to trust, especially when sharing their own stories of recovery with mental health service users and with professional colleagues. All referenced various forms of stigma and discrimination by mental health professionals, including their colleagues, towards HCPSs and

mental health service users. Participant 3 warned, "People who may seem to be friendly, may not be so friendly. You can never be too careful."

Participant 5 referenced specific instances where they experienced distress over the actions of colleagues whom they believed could be trusted. Participant 5 explained,

> You are so vulnerable. You open yourself up, and then you are working with people [referring to coworkers], opening yourself up to people and you think you can share all of this information about yourself, and they put it out there. They put it out there. And you got to work with these people. You know, it's like. You get traumatized again and again… You got to be careful.

Participant 5 suggested that HCPS should find "people who really care… you know there are certain people you can talk to." Participant 5 cautioned HCPSs to exercise caution when describing their story of recovery to non-peers. Participant 5 explained, "There are certain people that you just can't [talk to] because there is going to be gossip… it's not going to go or stay in a loving and safe place."

Participant 8 questioned whether HCPSs affiliated with the State Mental Health Authority could be trusted. Participant 8 described in detail their disappointment after a trainer suggested to their entire class that they should be "seen but not heard" in traditional mental health service settings. According to Participant 8,

> There was one time in the training where the instructor was telling the consumers that, yeah, you know, say you are in a hospital setting and, you know, and the doctors come up, and there would be a discussion about a client or whatever, you have to be actually seen but not heard. We have, we call it here in Hawaii, you got to make small body.

Participant 8 clarified the trainers were advising the class to "say nothing, make yourself less visible" and to not offer their perspectives or opinions in these situations, especially to physicians. Participant 8 emphasized,

> So they give you this intense endurance training and then they knock you down at the end. Where is this coming from? Who, and its not that, that is not in the manual […] I think that this is huge, especially with recovery. I'm supposed to get better and be better and

> then you shoot me down in the end? That puts me right back into doubting myself. I am not good enough to be here. I am not good enough to be here. You are going along with that stigma. That is what I am saying. Somebody threw that in there, and it was not in the books. It was not in the books! But they threw it in there. Where did that come from? And that stuck out to me because I was like hold up, wait a minute, you're going to preach to me for 2 weeks and now you are telling me that I don't have nothing to say even though you are saying that I do have something to contribute? Now you are telling me not to contribute? And not to be seen? Where is that in the manual?

Participant 8 described this encounter as having significantly changed their opinion of the HCPS program. They acknowledged feeling angry, disappointed, and frustrated with these trainers.

Disabling barriers with peer title. Participants described negative experiences and barriers they associate with having the peer specialist title. Participants explained the peer-designated title immediately identifies themselves to their coworkers and clients as someone in recovery from a SMI. Participants suggested that mental health professionals are not immune from stigma and discrimination, and several participants described feeling immediately ostracized by their coworkers. Participant 5 explained that they and other peer specialists were regularly told that they were "part of the treatment team" but nonetheless, they were "looked down upon" and "felt stigma from certain people," especially when having to collaborate and coordinate with other programs that do not employ peer specialists.

Participant 7 described their own experience assuming a new title where they lost status. Participant 7 explained, "instead of being like the most important person on the job or the second most important person in a work setting, I am now on the bottom. So that was totally a new experience for me."

Participant 8 suggested that stigma towards peer specialists is omnipresent and that it remains very difficult for mental health professionals to "see us as, you know, as a part of the health care system." Participant 8 emphasized that they do not identify themselves as a peer specialist. Participant 8 explained:

> Being a peer specialist means that I am part of a group. And, as I have learned, that group is being treated, I mean, we are not accepted. And that makes me push harder… That made me want to become more, become more of a voice, have a say so, it seems like that education was the important thing, you know, in the field. If there is more education you get, it's not really the practice, it seems like it's more about the credentials. The more letters behind your name were more important.

Participant 8 suggested that Hawaii's mental health professionals are reluctant to integrate and welcome peers into traditional mental health service settings, and this is a reflection of the system's belief in the recovery paradigm.

Participant 1 stated that their goal was to become a *prosumer*. Participant 1 described a prosumer as a mental health professional with lived experience and expertise in recovery, but who had an advanced degree and would not need to reference themselves as a peer specialist. Participant 1 referenced prosumers by name, including Drs. Patricia Deegan and Mary Ellen Copeland, whom they believed received respect from mental health professionals, since both had advanced degrees and had the power to choose whether to self-disclose they had a SMI.

Participants suggested that the peer-designated title prevented them and others from advancing in their own careers or from seeking employment in industries outside of behavioral health. Participant 5 explained:

> I am proud to be a Hawaii Certified Peer Specialist, but while looking for employment, while I was talking to people, you know, it was like, people started asking, what is a Hawaii Certified Peer Specialist? And I start talking about the things a Hawaii Certified Peer Specialists does, but it's like, when they look it up, it's right there - a person with a mental illness. We suppose to be the champions, but it's right there. It's supposed to be confidential… I have talked to plenty other people about that title and how it can hurt. How it hurts us from getting other jobs. And for people who do not understand, like I did not understand mental illness, I was like, why would you hire somebody with mental illness?

Participant 8 articulated the paradox they experienced having positively promoted the HCPS program for other mental health consumers while describing their frustration that the

training and title was a barrier to other opportunities. Participant 8 used the metaphor of being invited into a room where people with power could control their futures:

> Oh come in this room, come in this room, we got peer specialists. And then they close the door behind us – now you can't go any further. You are boxed in, and I am glad that you took this training, because we can now identify who are these people. Which is scary in it self! Because, what have I done? I had put myself out there where people can now identify me. And if there is no support, they can do anything they want with this information.

Theme 4

Completion of the Program Increased Their Confidence, Decreased Their Feelings of Isolation, Increased Their Empathy Towards Others with Mental Illness, and Broadened Their Perspectives and Worldviews.

Almost all the participants were complimentary of the program and endorsed the program for having positively impacted and transformed their lives. There were four main themes that emerged as participants described how the HCPS program positively impacted their lives. First, participants emphasized that the program normalized the experience of having a SMI and ending the isolation they felt. Second, participants described the program as significantly helping them to build confidence in themselves, and in their ability in helping others. Third, participants described having developed increased empathy for their peers (i.e., adults with serious mental illnesses). Fourth, participants attributed the program to broadening their perspectives of situations and events and helping them to think more critically and reflectively.

Ending the isolation and normalizing mental illness. Participants overwhelmingly endorsed the program for "ending the isolation" (Participant 1), normalizing the experience of being diagnosed and living with a mental illness, and developing a sense of camaraderie with other HCPSs who want to support others in their own recovery.

Most participants described feeling isolated and alone in their early recovery and attributed these feelings to stigma. For example, Participant 3 noted, "I was suffering. I don't know how to describe the situation I was in." Participant 3 later described:

> When I was diagnosed with a mental illness, I was stuck in a bubble trying to process what was going on with me. Accept it, and be ok with it. It took a long time for me to do that even before I decided then. I think that this is something really important because when I was first diagnosed, I did not have, I felt like I did not have much help. Because of stigma, you don't know who to talk to and who to trust. You know, me growing up in … they have a stigma towards mental illness. It's kind of like shame. Don't talk about it. Don't mention it. Don't seek medical advice. It's a small island. Everyone knows everybody. I was battling that and at the same time I was not feeling well.

Participants suggested that stigma and discrimination prevents others with serious mental illnesses from seeking mental health treatment. Participant 5 articulated their own stigma towards people with mental illness and their fear of receiving mental health services:

> I mean getting into the mental health system was really scary for me because I was not around people who, you know, who have mental illness. You know, it was kind of scary walking into that… So, I never knew about stuff like that [referring to mental health services] so it was scary for me… Cause you know, when you go, you hear about crazy people, mental people, you like kind of have this stigma. So, for me, to walk into that, I was just kind of like nervous and scared.

Participant 3 described their frustration with having postponed seeking treatment because of stigma and acknowledged the role of their primary care provider who intervened:

> I never sought help for it [mental illness] because of stigma… I did not even know it [referring to mental illness] was a problem until it became a problem. I could not function in school. I could not function at work. I could not function in my daily routine. I just felt like something was wrong. And so I went to a doctor, and it was like for a regular check-up, and I just broke down and cried.

Participants described feeling anxious assuming a new role and identity as a person with a disability, and how the program itself, later in their interview, changed their thinking about mental illness. Participant 2 explained:

> Mental illness did not even exist to me. I had no idea that it was an illness to begin with. It was a foreign concept. It's kind of like going to a new State and then you become the

> minority. In Hawaii, we don't experience that because everybody is different. They come from different backgrounds and different cultures. We are all types of cultures from the rainbow. We don't know what its like to experience being a minority or what it is to be a minority.

Participants 2, 3, and 5 acknowledged the role of informal peer support in motivating them to seek mental health treatment; none of the participants received services from a peer specialist. All three endorsed mental health treatment in helping them move forward in their own recovery. Most participants agreed that there remain a large number of people with serious mental illnesses in the community who are not receiving adequate mental health treatment. Most believe that integration of peer specialists across the system would increase the number of people in need of help to receive mental health services.

Participant 2 was actively involved in peer-run support group prior to applying to the program. Yet, Participant 2 was inspired after learning that many people in the community are in recovery, and this inspired them to continue forward with accomplishing their goals following the training. Participant 2 expressed:

> I like the fact that I got to meet peers from the other islands. I had a really good bond with them. It was really helpful… Just meeting others that have, like for me, I always feel like I am the only one that struggles with my illness and you know, and then when I meet others that going thru the same struggle and they are making it, and we want to get ahead in life. So that helped me realize that, eh I can do this. I am not alone, you know.

Participants 2, 4, 6, and 7 described the camaraderie and bonds they made with other HCPSs and shared how these bonds have helped them in their own recovery. Participant 6 described how the experience of having participated in the program helped them to see that they were not alone. Participant 6 explained, "I got to meet other people with different perspectives and different stories in similar situations," and they later noted the unique experiences they shared with their classmates and with others who participated in the program. Participant 6 emphasized, "I remember at the start of the classes, introducing ourselves and kind of opening up and then

towards the end breathing a sigh of relief." Participant 6 expressed their surprise that "mental illness affects everyone. Not just people on the streets."

Participant 5 used the metaphor throughout their interview of "riding waves" as they described their experience of moving forward in their own recovery. They first described this wave when discovering mental health services and supports. They described the next wave being later when following other HCPSs who were looking for opportunities to help others. Participant 5 later remarked on the significant impact the HPCS program had on them to recognize that they were no longer alone and that they had purpose. Participant 5 emphasized:

> I was not alone. That feeling, like OK, other people are just like me trying to survive. This is where my life started… I had no purpose. I had no real purpose in life. I had to become more responsible. I had to start thinking about other people and learning. It was such a learning process for me. Learning about myself. What I can and what I cannot do. And just being OK with you know making some decision in my life to where I did not feel like I was able to know, you know? And, becoming more empowered, yeah?

Participant 7 expressed their appreciation to their classmates for taking the course and training seriously. Participant 7 explained,

> I was very impressed with the students in the class. Some of them came from the outer islands. Some of them were already working in the field. And the students were also very passionate about the content. And they were, the students were very verbal in their responses, it was, the class was interesting for everyone. Not only for the instructors but the students as well. The students cared a lot about the content as well.

Participant 7 was complimentary of the students and described them as having helped empower many people in the community through employment and through informal peer-run support groups.

Almost all the participants endorsed the program for having changed their lives, and in particular, how the program should have been introduced earlier in their recovery. Participant 1 offered the following when reflecting back on the impact the program had on their recovery:

> It [referring to the HCPS program] changed me significantly. I wish, I know that I can't change the past. But, I wish I had known this before, it would have really helped cut down on all the drama, and all the pain, and everything that I had been through. And like when I was diagnosed with my mental illness, I just, if I had been introduced to this early on, it would make things be put into a better light for me.

Increased self-confidence. Participants overwhelmingly reported that the HCPS program and their work as a HCPS increased their self-confidence. Participants agreed that graduating from the program demonstrated to themselves and others that they could be successful. Participant 8 emphasized the symbolic importance of graduating and what it meant for their future:

> Graduating. Graduating. Becoming a peer specialist. That was one of the most exciting times in my life – having completion. The fact that I really, I have completed something. And it's actually, I'm on my way to being able to be certified and to help people…That's huge for a consumer is to be able to complete, instead of just coping with a situation. The completion of it helps you to resolve other issues in your life like I can complete this. I can do this!

Participant 6 explained, "It gave me more confidence in myself… I can accomplish and be successful while dealing with a mental illness." In addition, participation in and graduating from the program secured confidence in their supporters. Participant 6 highlighted, "It gave them [referring to their family] and me the confidence that I needed that I can take care of myself when my family and supports are not around."

Participant 4 described how the program helped them to feel more confident helping others, and that by helping others, they recognize how much they have grown in their own recovery. Participant 4 highlighted:

> I enjoy it more now. I am more certain of what I am doing. I feel more confident. I am able to also see what others do. I have an understanding of what others think is the right to do. It has given me more confidence to help people… You really feel good when you help people. You are not so focused on yourself. You are helping others. It's great. You can see where you were before. You can see the progress you made when you're helping other people.

After having worked as a peer specialist, Participant 2 is seriously considering going back to school and capitalizing on their lived experience to support others in their own recovery from serious mental illness. Participant 2 explained:

> It [referring to the HCPS program] made me realize that how much more peer specialists we need out in the community. Like there is so much people that need help. And it likes motivates me to want to be like, I know that I am peer specialist, but I want to be like a case manager or somebody even more because from what I seen, is like, they don't really help the peers like how a peer specialist can help. I think when the clients found out that I was a peer then they kind of opened up more and we would have fun.

Participant 8 also attributes the HCPS program to helping them recognize the importance and power of language and how it can be used to exclude or empower other mental health consumers. Participant 8 was complimentary to the HCPS program for helping them develop the skills and ability to use language in helping others, and that this skill helped them to become more confident in helping others. Participant 8 explained:

> And then it was explained to me is that you take the difficult or complex and you reduce it down for people to be able to understand. Then I was like, right? That, that's my purpose. Because, you know, jargon is jargon. I can, I can jump in and one of the things in mental health that caught me was the word cognitive. Because I used to be like, you know, seeing the word being spelled out and then, you know, I went to go look it up, it says thinking. That, so why are they, why are they, why not just use the word thinking. So, I was able to when people were getting stuck on the jargon, I was able to explain to them, oh that just means thinking. It just means thinking. Cognitive behavioral therapy is just thinking about your behaviors.

Increased empathy for others. Several participants acknowledged having stigma towards others with serious mental illness and attributed their involvement and training in the HCPS program to developing increased empathy towards other adults in their early recovery from serious mental illnesses. Participant 1 highlighted:

> My eyes have opened up to people. How I look at things and suffering. You know? Even though I myself, suffered from mental illness, and you know, at one time very bad, you know from medicine and all kinds of things and situations. You know? I had looked at mental illness in a very negative way, but now I am very sympathetic, empathetic, you know? Now I have a deeper understanding. And I, I understand, and I feel love for these

> people… [They] cannot help themselves. They have lost their minds. They need the help. These are the ones we help.

As reported earlier, Participant 5 acknowledged having stigma towards others with SMI. They described experiencing fear when first walking into the room on day one of the HCPS training. In retrospect, Participant 5 recalls that participation on the first day changed their attitude and understanding of others, and increased their empathy and yearning to help others in recovery.

Broadening perspectives. The majority of participants said that the HCPS program had broadened their views and perspectives of people and situations. Participant 1 highlighted,

> It broadened it. It broadened my view on a lot of things. I have, my heart has opened up more. It's deepened, you know? I have a far better understanding of situations. You know? I am not so quick to judge situations, or people, or circumstances. You know? I always say, 'well we just don't know.' We just don't know what's going on.

Participant 7 used similar language on broadening perspectives. Participant 7 explained, "I would say, the primary way it's changed me is that I have, I have a tendency to look at things from other people's points of view… Just broadening my perspective on people in general."

Participant 6 reported, "It has opened my eyes. No longer being stuck in tunnel vision. I can see other people's perspectives. Not just seeing what you want to see. Get to know their story too. Trying to piece together their story and how it affects them."

Participant 3 attributed the program for them not "taking things at face value" anymore. Participant 3 offered a scenario to help explain how their perceptions and perspectives changed since becoming a HCPS. The scenario included self-reflections that emphasized the various reasons or antecedents that preceded the specific event. Participant 3 reported that this exercise helped explain that people don't always have control over specific situations or they way others

think; however, it highlighted the ability for people to choose how they react or respond to the situation or event.

Participants attribute active listening, a module taught in the HCPS curriculum, to having helped them broaden perspectives of situations and perspectives from other points of view. Participant 2 explained the importance of "taking notes… always repeat the question or the answer from the consumer, from the peers, to make sure that its what they are saying, like don't add your own words to it." Participant 7 recalled,

> I remember in the training, the emphasis put on questions. How questions, how to ask, there is a topic on how to ask questions. That was really, that was really one of the most valuable assets of the training. Because, depending on the questions you ask, how you ask the question, how you respond to the question, it can affect the, how the person, how the person you are trying to help responds. So, I would say that was really important.

Participants acknowledged the program for helping them to be more introspective and reflective in their thinking. They also emphasized that the training helped them to listen differently and that this skill in learning how to understand others was very positive in their own recovery.

The aim of the first-level inductive analysis was to give voice to HCPS who chose to participate in this study. An inductive approach using grounded theory identified four main themes: (1) prior to training and certification, the prospect of participation instilled hope of moving forward in their own recovery and helping others with similar lived experiences; (2) subsequent to training and certification, the lack of follow-up support services and few employment opportunities resulted in feelings of frustration and hopelessness; (3) ongoing systemic stigma and discrimination maintain barriers to integration; and (4) completion of the program increased their confidence, decreased their feelings of isolation, increased their empathy towards others with mental illness, and broadened their perspectives and worldviews.

Second-Level Analysis Utilizing Critical Disability Theory

In this section, I describe the experiences and perspectives of participants through the lens of Rocco's (2005), Devlin and Pothier's (2006), and Hosking's (2008) conception of CDT. Most themes in my first-level analysis align with CDT elements and propositions. Themes were not mutually exclusive and often applied to two or more CDT elements. In addition, I include a critical review by using a CDT lens of policies and processes specific to peer specialists in Hawaii.

Disability is socially and culturally constructed. The concept and definition of a peer specialist, like disability, has no essential nature – it is socially and culturally constructed (Devlin & Pothier, 2006). There is no consensus across the nation on who qualifies as a peer specialist. The general screening criteria outlined in Kaufman et al. (2017) review of peer specialists training and certification programs highlights the differences in each State's minimum requirements to apply for and be accepted into their peer specialist program.

In Hawaii, there are discrepancies in definitions between the federal and state agencies that fund peer support services (i.e., CMS and the State of Hawaii's Department of Human Services) and the state agency that assumes control over the HCPS program (i.e., the State Department of Health). The CMS (2007) and the State of Hawaii's Department of Human Services (DHS) Med-QUEST Division's (the Single State Medicaid Agency; 2013) entered an agreement to fund peer support services for Medicaid beneficiaries in 2013. CMS (2007) and DHS (2013) define peer providers in the State Plan Amendment as "self-identified consumers who are in recovery from mental illness and/or substance use disorders" (p. 3; CMS, 2013, p. 4). The Hawaii State Department of Health's Adult Mental Health Division (Hawaii's State Mental Health Authority; 2012) restricts eligibility to the HCPS program by stating peer providers must

"have a primary diagnosis of mental illness or co-occurring disorder. A single primary diagnosis of a substance use disorder does not meet certification standards" (p.4). Further, the State Mental Health Authority restricts eligibility to persons who "self-identify as a person who has received or is receiving mental health or co-occurring services as part of his or her personal recovery process" (p.4).

Devlin and Pothier (2006) highlight the contentious nature to the politicization of a disabled identity. In addition, Barnes, Mercer, and Shakespear (1999) highlight that mental disorders themselves are social constructs that change over time and are culturally defined. Here, Hawaii's State Mental Health Authority further restricts eligibility by giving primacy to specific medical disorders and to persons who had or are currently receiving mental health or co-occurring services.

Language used in the discourse of disability is inherently political. The experiences and perspectives of HCPS interviewed in this study highlight the ideological and political implications associated with identifying as peer specialists. Four participants acknowledged the title of peer specialist as being problematic as evident in the theme of *disabling barriers with having the peer title*. The title, according to participants, immediately discloses an aspect of themselves they may not want immediately identified to others. Participants suggested the title conveys a negative connotation that may limit future employment opportunities in other industries outside of behavioral health. In addition, participants confirmed the title also conveyed a negative connotation to colleagues in traditional mental health service settings.

Labels and titles evolve when they reference something in society that is considered to have a negative attribute (Hosking, 2008). Labels are also used to create hierarchies. In this study, participants introduced other labels, including prosumers, peer coaches, and peer mentors to

differentiate different peer provider types. Participant 1 endorsed the term and their desire to become a prosumer since it provided them an option to choose whether to disclose their hidden disability. Devlin & Pothier (2006) pointed out, "if marginalization or discriminatory consequences are associated with being categorized as disabled, there may be an incentive to act as though one is not disabled" (p. 15). Other participants expressed interest in continuing their education to assume other traditional roles (e.g., case manager) in the system.

Participants described the importance of distinguishing themselves from peer coaches and peer mentors as outlined in the theme of *hierarchies between peer provider types*. Participants described their understanding and belief that they should be recognized differently because they are credentialed as HCPSs. There was nothing in the peer-reviewed or grey literature that discussed hierarchies of differences between peer provider types; however, Bayes and Neill (1978) describe the various problems paraprofessionals have endured in mental health service settings.

Citizenship entails a capacity for productivity. Productivity and employment were highly valued by participants. Almost all decided to apply for and complete the HCPS program as highlighted in the theme of *expectation for employment*. Adults with SMI, like most adults in Western society, do want to work and view employment as central to their recovery (Drake, Bond, Goldman, Hogan & Karakus, 2016; Dunn, Wewiorski, & Rogers, 2008). SAMHSA (2012) identified *purpose* as one of four major dimensions that support a life in recovery. Purpose, as described by SAMHSA (2012), references meaningful daily activities, including employment as instrumental in an individual's recovery. Employment supports recovery by establishing vocational identities that enhances self-esteem, self-pride, and sense of competence (Dunn et al., 2008). Almost all described the importance and value employment had in their own

recovery, and the disappointment, frustration, and sense of betrayal they felt when peer specialist positions were not available in the community. This was evident in the theme that participants *felt misled about employment opportunities*.

Commodification exploits and marginalizes people with disabilities. In the theme where participants *felt ambivalent about employment,* participants described disabling barriers that maintained inequalities in income and employment for peer providers. Participants described the ambivalence they had when applying for peer specialist positions after learning about its low compensation. Participants were aware of the risk of losing Social Security Disability Income and Medicaid and described it as a powerful work disincentive.

Hire Abilities Hawaii (2016) highlighted that Hawaii is one of only four States that has not implemented a Medicaid buy-in program for working people with disabilities. The Medicaid Buy-in program allows people with disabilities to work while accessing comprehensive health care services and supports they need that may not be available through employer-sponsored health plans (Kaiser Family Foundation, 2015). Without this option, people with disabilities, including peer specialists, have to choose between employment and qualifying for Medicaid.

According to Swain et al. (2003), "Professionals have been accused of engaging in 'social closure' whereby they seek to maximize their rewards and status by restricting the opportunities of others, policing their own activities and monopolizing a particular social and economic niche" (p. 133). Participants provided examples in how healthcare and social service professionals assert their dominance and maintain power over peer providers in traditional care settings. For instance, participants described instances where professionals ignored their recommendations as HCPSs when discussing strategies for helping their clients move forward in their own recovery. Participants also noted that some behavioral health providers would

minimize their role and contributions as peer specialists as evident in the menial work they were tasked to perform in their internship and work settings. Minimizing the role of HCPSs was difficult since participants emphasized their *desire to help others* as one of the main reasons they decided to apply for and complete the program. On the other hand, participants also identified mental health professionals who encouraged them to apply for the HCPS program to consider a formal helping role in the mental health service system (see *encouragement from others to consider formal helping roles*).

Participant 8 was the most critical of the HCPS program and suggested that *lack of formal and ongoing support* was intentional by the system. They emphasized their frustration that the trainers suggested for HCPSs to continue relinquishing control to mental health professionals by remaining quiet in traditional mental health treatment settings. Participant 8 hypothesized that mental health professionals possibly felt threatened by peer providers. Participant 8 and others were not familiar with the emerging literature on peer support, but referenced anecdotal stories and use of their own stories to describe the effectiveness of peer support services. They suggested and emphasized the positive outcomes they had as employees in traditional mental health service settings.

Most participants agreed that the HCPS program lacked adequate resources and an infrastructure to successfully integrate HCPS in different settings across the behavioral health continuum of care. Participants acknowledged that traditional mental health service settings and their supervisors were not equipped to successfully support HCPSs as employees. One of the biggest challenges for participants was carefully choosing which parts of their own lived experiences should be shared, especially with their professional colleagues in work settings. As paid employees, their stories were no longer confidential and protected by privacy laws. Unlike

other behavioral health professionals who may choose to keep their disabilities hidden, HCPSs are expected to make known their disability status. Participants described the importance of learning who to trust and the value of establishing clear personal and professional boundaries as outlined in the theme of being employed in *trauma-inducing work environments.*

Disability exists along a continuum of human variation and is multidimensional. All participants self-identified as being in recovery from a SMI. The visibility of their disability is contextual. As described by Devlin and Pothier (2006), the context, setting and situation in which a HCPS resides determine its significance. Participants acknowledged that stigma and discrimination towards mental illness is pervasive in society and in traditional mental health service settings.

Participants recognize the potential implications of identifying as a HCPS to others outside the health care system. Although mental and substance use disorders are common (SAMHSA, 2017), participants recognize that others may assume that their diagnosis defines them. In addition, HCPS recognize that they too are not immune from stigma and discrimination. Several participants acknowledged their own stigma towards SMI and attribute the HCPS program to *increasing their empathy* and *desire to help others* with similar life histories and experiences. Further, participants recognize and attribute the training to helping them better recognize and appreciate the range and diversity of mental disorders that comprise the SMI population.

Ignoring diversity limits equality and full participation of people with disabilities. There is no information on the number of individuals who apply to the HCPS program. There is no information on the number of applicants selected to participate. In addition, the criteria for selecting candidates are not known and the composition and selection criteria for the committee

that chooses applicants are not known. It is not known, but assumed using CDT, that the full range and diversity of serious mental illnesses are not taking into consideration. CDT suggests that able-bodied norms and assumptions may influence the selection of candidates.

Of those who are accepted into the program, participants expressed in the theme that participants felt *sad, concerned, and frustrated for the forgotten*. This theme attributed failure of individuals who separated from the program prior to receiving their credential to personal misfortune. Participants suggested the format, organization, and delivery of the curriculum did not take into consideration the range and diversity of serious mental illnesses. Inclusion and full participation of mental health service users accepted into the program demands that differences be acknowledged and understood as inevitable and expected. Dismissing these differences and choosing to not make adaptations to the delivery, format, and organization of the HCPS curriculum ensures that some mental health service users never have access to becoming a HCPS, and those who do pass, may attribute other reasons for their classmates' failures.

Self-determination and equality are contingent on true minority group status. Participants suggested that self-determination of mental health consumers who apply to the HCPS program may never be realized if the decision to select candidates remains in the hands and control of the State Mental Health Authority. As described throughout this paper, the criteria and processes for selecting candidates is not known.

Using CDT as a lens to further analyze the discrepancy between definitions of peer providers brings attention to the power the State Mental Health Authority assumes by excluding people who choose not to use traditional mental health services (see eligibility criteria) when the concept of recovery emphasizes the need and right for individuals with SMI to have access to non-professional and self-directed services (Chamberlin, 1978, 1984; Zinman, 1982). Further,

the State Mental Health Authority's definition of peer providers endorses the medical model of disability by stating that one of seven minimum requirements is having a primary diagnosis of mental illness or co-occurring disorder. Although the HCPS application does not specifically require applicants to submit attestation statements that applicant have received mental health services and have a primary diagnosis of mental illness, self-determination will never be fully realized as long as people with disabilities have to demonstrate that they are *qualified* individuals.

Ableism is so ordinary and pervasive that it's invisible to the non-disabled. Almost all participants described instances where mental health professionals made decisions on behalf of mental health service users. Often, mental health professionals who exercise control over these mental health service users refrain from considering their input or needs. Participants also highlighted that healthcare professionals minimize and undervalue the experiential and informal support that is the hallmark of peer provider services.

The voices and perspectives of people with disabilities are deftly suppressed. In the theme that identified *lack of consumer advocates in traditional mental health service,* participants described the various ways healthcare professionals exercise power and control over adults with SMI. Participants 2, 6, and 8 collectively emphasized the need and importance for more mental health consumer advocates to be embedded in traditional mental health service settings. All agreed that mental health professionals assumed to know what were in the best interest of mental health service users without actively engaging and supporting their clients in deciding for themselves what the wanted or needed. Participant 8 was frustrated and disappointed that their peers (i.e., the trainers) would privilege the voices and perspectives of mental health professionals. Participant 8 was clearly upset suggesting that peer specialists

would never be successfully implemented in community-based treatment settings if HCPSs believed there voices were not equally valued and important as their professional colleagues.

Another theme that aligned with CDT was fear of potential reprisal for participants speaking negatively of their employers, their colleagues, the system, or about other HCPSs. Participants identified HCPSs by name and suggested these persons had difficulty securing employment as peer providers since they offered criticism about the system to able-bodied administrators. Almost all participants were complimentary of the HCPS program and the Office of Consumer Affairs; however, participants suggested that the Office was not adequately staffed and did not have access to resources for ensuring the success of the program. Participants expressed concern that speaking negatively about the HCPS program may jeopardize its future.

The aim of the second-level analysis was to describe the experiences and perspectives of participants through the lens of Rocco's (2005), Devlin and Pothier's, (2006) and Hosking's (2008) conception of CDT. Themes from the initial analysis and a critical review of policies specific to peer specialists in Hawaii aligned with CDT elements and propositions. Together, the first and second-level analysis provide unique insights into potential motivating factors for Hawaii's mental health service users applying to the HCPS program. Findings also highlight systemic inequalities and organizational barriers hinder the integration and maximum utilization of peer specialists in traditional mental health service settings. Lastly, first-level findings suggest the training and credentialing process was a transformative experience that positively impacted participant's lives.

CHAPTER 5: SUMMARY, CONCLUSIONS, DISCUSSION, AND IMPLICATIONS

This chapter presents a summary of the study and conclusions drawn from the findings presented in Chapter 4. It provides a discussion on the study's limitations; implications for social work practice, theory, and policy; and future research.

This is the first study to examine why mental health service users in Hawaii choose to become peer specialists. No study has examined the recovery experiences and perspectives of Hawaii's mental health service users after they become certified as Hawaii Certified Peer Specialists. The purpose of this study was to examine the experiences and perspectives of Hawaii's mental health service users in becoming peer specialists and what their perspectives and experiences can possibly tell us about their recovery. Three research questions guided this study:

1. Why do Hawaii's mental health consumers choose to become peer specialists?
2. What are Hawaii's peer providers' experiences following certification?
3. How did the Hawaii Certified Peer Specialist (HCPS) program impact their recovery?

Qualitative methods were used to explore the experiences and perspectives of eight peer providers certified through HCPS program. Data were analyzed at two levels. At the first level, an inductive approach using grounded theory identified the following four main themes: (1) prior to training and certification, the prospect of participation instilled hope of moving forward in their own recovery and helping others with similar lived experiences; (2) subsequent to training and certification, the lack of follow-up support services and few employment opportunities resulted in feelings of frustration and hopelessness; (3) ongoing systemic stigma and discrimination maintain barriers to integration; and (4) completion of the program increased their confidence, decreased their feelings of isolation, increased their empathy towards others with

mental illness, and broadened their perspectives and worldviews. At the second level, themes from the first-level analysis were examined through a critical disability lens.

Summary of Findings

This qualitative study provided an in-depth understanding of participants' experiences and perspectives. In this section, I summarize findings from the study and describe the relationship of my study to the existing literature.

Prior to training and certification, the prospect of participation instilled hope of moving forward in their own recovery and helping others with similar lived experiences. Participants identified various reasons for having applied to the HCPS program. Five primary themes emerged from the data. First, participants collectively recognized the need for more consumer advocates in traditional mental health service settings. Participants emphasized that they believe their involvement in the program would provide hope and encouragement to others, and address a perceived shortage of HCPS across the State. Participants described instances where mental health professionals exercised control over mental health service users in traditional mental health service settings. Their stories, along with the fact that most participants expressed concern of potential reprisal for speaking critically of the behavioral health system in Hawaii, aligned with the CDT element that the voices and perspectives of people with disabilities are deftly suppressed (Rocco, 2005).

Second, participants applied to the program with the expectation of employment. In Western mainstream society, citizens often identify themselves in relation to their profession or employment (Costa et al., 2017). CDT proposes that citizenship entails a capacity for productivity, and that value placed by participants on competitive employment in this study were not surprising.

Third, participants were encouraged from others, including mental health professionals, to apply to the program or consider another formal helping role in the behavioral health system. Participants described this encouragement as being instrumental in their decision and provided them with hope to apply to the HCPS program. SAMHSA (2012) recognizes the role relationships and social networks have in supporting adults with SMI to move forward in their own recovery. As described by participants in this study, their supporters offered encouragement to consider a new role that moved them beyond an illness-dominated identity to another that emphasized and reinforced a greater sense of autonomy and personhood.

Fourth, participants applied to the program with the hope of learning about mental health and mental disorders in general. Access to education about mental disorders is critical for adults with SMI to make informed decisions about their care and their own recovery (Mueser et al., 2012); however, most adults with SMI who receive services from traditional mental health service settings often receive education about their diagnosis and its treatment in an unstandardized way (Corrigan et al., 2016). It is unknown how much information mental health services users learn and retain from unstructured and unstandardized teaching methods delivered by staff not trained as educators for adult learners. Participants identified early in their recovery that they did not know about their diagnosis, the system, and the various resources and supports available to help them and others move forward in their own recovery.

Fifth, participants described a desire to help others in their own recovery from SMI. Intrinsic motivation to help others was not a unique finding to this study (Moran, Russinova, Yeon Yim & Sprague, 2014). The desire to help others move forward in their own recovery is common among mental health service users who choose paths in supporting others with similar

life experiences. The literature proposes different recovery models that provide some insight into this desire of helping others.

Davidson, Roe, Andres-Hyman, and Ridgway (2010) reviewed the existing body of literature where different investigators proposed 10 models that describe a series of "inter-related stages which they hypothesize together constitute an overall process of recovery" (p. 213). Davidson et al (2010) organized and distilled the various stages proposed in these models into an emerging model of stages of change in mental health recovery. In the last stage, living beyond disability, two models (i.e., Jacobson, 2001; Ridgeway, 2001) describe the value and "deep source of meaning through being actively involved in a process of giving back, in helping other people who experience psychiatric disabilities to have an opportunity to begin their own journeys of recovery (Ridgway, 2001, p. 339).

Subsequent to training and certification, the lack of follow-up support services and few employment opportunities resulted in feelings of frustration and hopelessness. Participants attributed the perceived lack of follow-up services and lack of employment opportunities to shared feelings of frustration and hopelessness. There were three general subthemes: First, participants described feeling misled about employment opportunities as peer providers. Salzer, Katz, Kidwell, Federici, and Ward-Colasante (2009) recognize that successful implementation of peer specialist initiatives are partly contingent on ensuring that employment opportunities are available for peer specialists. Other studies (e.g., Davis & Pilgrim, 2015; Gates & Akabas, 2007; Moll, Holmes, Geronimo, & Sherman, 2009; Silver & Nemec, 2016) have examined factors that support the successful implementation of peer specialists in traditional mental health service settings; yet, none specifically have examined the lack of employment opportunities for peer providers and the impact this has on their recovery. As described earlier,

CDT proposes that citizenship entails a capacity for productivity. Thus, limited opportunities for peer providers to secure employment in traditional mental health service settings may negatively impact HCPSs' own recovery. Further, commodification of disability prevents people with disabilities from assuming positions that would challenge the role and power mental health professionals assume in traditional mental health service settings. These are two areas that should be examined in future inquiries that examine implementation factors that facilitate or create barriers to integrating peer specialists in traditional mental health service settings.

Second, participants described their disappointment with the lack of ongoing support, formal communication, and continuing education opportunities made available through the State Mental Health Authority. The literature does not reference other examples where peer providers expressed their frustration and hold accountable the State Mental Health Authority (or designated accreditation body that trains or certifies individuals as peer specialists) for not providing ongoing support and continuing education. Participants agreed that the HCPS program lacked adequate resources and an infrastructure to successfully integrate HCPSs in different settings across the behavioral health continuum of care; yet, many described their frustration that the support for them and others were not available. The lack of committed resources and supports for the HCPS program suggests the system continues to honor and preserve the medical model by committing the majority of funding to professional interventions and support services.

Third, participants expressed sadness, concern, and frustration for mental health service users who participated in, but separated from the program before receiving their certification (i.e., "the forgotten"). Several participants became noticeably upset when describing the separation of mental health service users from the HCPS program. Participants were critical of the program's format and duration. Participants attributed the format and duration as they described the training

as an *endurance test* where students sat for hours reading from a manual and being expected to take notes. Participants suggested that most students had not been in a formal classroom setting for decades. Others highlighted that the training did not take into consideration the range and diversity of serious mental illnesses that would make it difficult for anyone to manage and recall specific information presented in this training. Inclusion and full participation of mental health service users accepted into the program demands that differences be acknowledged and understood as inevitable and expected. Dismissing these differences and choosing to not make adaptations to the delivery, format, and organization of the HCPS curriculum ensures that some mental health service users never have access to becoming a HCPS, and those who do pass, may attribute other reasons for their classmates' failures. Further, there were concerns that no specific supports were made available for the forgotten.

Ongoing systemic stigma and discrimination maintain barriers to integration. Participants described various ways that systems hinder the integration of peer specialists in traditional mental health service settings. Four themes emerged that were related to stigma and discrimination: First, participants described their own ambivalence about competitive employment in general. Specifically, participants were concerned about losing their Social Security benefits and Medicaid coverage. Bond, Xie and Drake (2007) highlight, "There is little question that receipt of disability benefits creates a powerful disincentive to seeking out work" (p. 1413). Drake et al. (2016) agree that Social Security disability programs involve many different disincentives preventing beneficiaries from entering or returning to work.

Participants also attributed their ambivalence to working as peer specialists in traditional mental health service settings to inadequate remuneration. A number of studies suggest that low compensation for peer specialist positions prevent peer providers from emancipating themselves

from disability entitlements (Miyamoto & Sono, 2012). A recent survey of 597 peer supporters across 44 States (not including Hawaii) included data on compensation of peer support providers (Cronise, Teixeira, Rogers, & Harrington, 2016). The average compensation of peer providers across the nation was $10 to $20 per hour, with the majority of peer providers (60.5%) earning $10 - $15 per hour. In Ahmed, Hunter, Mabe, Tucker and Buckley's (2015) study of the professional experiences of peer specialists in Georgia (n=84), participant's experienced similar issues as HCPS regarding remuneration and suggested:

> It is clear that traditional care systems even as they have embraced recovery have not provided enough full time jobs with adequate compensation and benefits that are commensurate with the educational attainment of peer specialists. Peer specialists are not only under-employed, but they may experience a form of wage discrimination in which they are paid less than others of similar levels of education (p.435).

Remuneration in this study was a sensitive issue. Remuneration is indicative of the value of peer support provider positions in traditional mental health service settings. Further, remuneration and disincentives confirm CDT's proposition that commodification exploits and marginalizes people with disabilities.

Second, participants described a hierarchy across peer provider types where some participants assumed their position as peer specialists were more specialized and advanced than other peer providers in Hawaii. My review of the literature did not find other studies that examined hierarchies of peer providers; however, Bayes and Neill (1978) outlined and delineated the hierarchical structure in which peer specialists operate and practice. The hierarchical structure that Bayes & Neill (1978) describe is relevant to today's behavioral health service system as it was forty years ago.

Traditional mental health service settings are organized into rigid, complex divisions of labor and authority where individuals occupy roles with various amounts of power and

responsibilities (Bayes & Neill, 1978). Bayes and Neill (1978) note that employees come to realize their placement within this framework, and eventually come to understand and realize that "the physical and social structure of these organizations is patterned after the general hospital with its 'rigidly hierarchical, caste-like social structure', based on the distinctions between professional disciplines" (p.138). The levels of this hierarchy, rooted in the medical model, gives authority to the profession of psychiatry. Thereafter, the levels of this hierarchy, in descending order, are the professions of psychology, nursing, and social work (Bayes & Neill, 1978).

Peer specialists, by definition, are paraprofessionals. In Hawaii, and in other States, the minimum education requirement for peer specialists is a high school or general equivalence diploma. Although Bayes and Neill (1978) did not specifically identify peer specialists in their work, they suggest that paraprofessionals "occupy positions at the bottom of the level of the lowest professional caste" thereby limiting their authority, autonomy, and perceive competence (p. 138). Bayes and Neill (1978) also note that functional hierarchies exist within and across some castes (e.g., management, administrators), and that movement between and across these functional areas and hierarchies are contingent on educational attainment and licensure. Thus, peer specialists who consider traditional mental health service roles may become prosumers who may choose to not disclose their lived experience and experience in recovery.

Third, participants remarked that traditional mental health service settings in Hawaii were trauma-inducing work environments. Participants acknowledged the cumulative effects of multiple work related stressors, including exposure to secondary and vicarious trauma, to negatively impacting their emotional, psychological, and physiological wellbeing. Participants described the importance of self-care and establishing firm personal and professional boundaries

with their clients and professional colleagues. Participants also emphasized and highlighted that overt and covert forms of stigma and discrimination maintained trauma-inducing environments.

Participants also identified a number of other work-related stressors that were unique to peer providers, including role ambiguity, negative staff attitudes, and stigma as factors that contributed to cumulative emotional and psychological trauma. Participants described situations in their work place or internship where their role as peer providers were minimized and questioned. Several described situations where they and other peer providers felt they had to prove themselves to gain respect and to counteract negative assumptions made by other staff. Participants also described various levels of acceptance by their respective colleagues. Several participants suggested that mental health professionals, including their supervisors, do not understand and appreciate the unique role HCPSs have in helping mental health service users move forward in their own recovery. Role ambiguity, role conflict, and role confusion are not unique experiences to peer providers in Hawaii (see Carlson et al.,2001; Chinman et al., 2008, 2012; Dixon et al., 2012; Moll et al.,2009; Salzer et al., 2002).

In other studies that have examined the experiences of peer support providers in traditional mental health service settings, peer specialists described an evolution of acceptance and integration into interprofessional mental health care teams through increased interactions that allowed mental health professionals to better understand the peer specialists role and capabilities (Asad & Chreim, 2016). Role clarity has been shown to be a strong predictor for employee satisfaction for peer specialists in traditional mental health service settings (Davis, 2015). In Kuhn, Bellinger, Stevens-Manser & Kaugman's (2015) study of peer specialists in Texas, the authors examined workplace integration indicators and found that the supervisor's understanding of the peer specialists' job role was significantly related to job satisfaction. In

Salzer et al. (2009) study of peer specialists in Pennsylvania, participants' employment satisfaction rates of being a peer provider in traditional mental health service settings were also high. Participants attribute their job satisfaction to supervisors creating a welcoming and supportive work environment, and to professional colleagues who respected and accepted them (Salzer et al., 2009). In national survey of peer providers (n=498), most (80%) agreed that they felt respected as an equal members of the interprofessional treatment team (Cronise et al., 2016).

Several participants in this study acknowledged that they exercised caution from describing their own lived experience of SMI with professional colleagues. As highlighted in this study, *learning who to trust* was an important lesson for peer providers as they navigated and maintained their position and role on different mental health treatment teams. Several suggested that their stories may be used against them and expressed concern that they were not protected by the same legal private and confidentiality laws outlined in federal and state statutes. In Asad and Chreim's (2016) study that also examined the experiences as peer providers, participants in this study viewed disclosure to professional colleagues very differently. They viewed disclosure of their own lived experience as instrumental in advocating for clients needs and to educating others on the team to alternative views.

Fourth, participants described disabling barriers (e.g., discrimination) with having a specific tile that labeled them as peer specialists. This finding was not unique to HCPSs (Silver & Nimic, 2016). CDT posits that language used in the discourse of disability is inherently political, and that changes to the label or title are inevitable and expected. For example, several authors (e.g., Pitt et al., 2013) refer to peer specialists as consumer-providers, and there is now evidence that systems that employee peer specialists (e.g., Hawaii's Department of Health) are recruiting peer providers under a different designated title.

Completion of the program increased their confidence, decreased their feelings of isolation, increased their empathy towards others with mental illness, and broadened their perspectives and worldviews. Participants collectively endorsed and described the program as having positively impacted and essentially transforming their lives. Findings from this study suggest that being trained as a peer specialist, and in some cases, working as a peer specialist helps to facilitate recovery. The rewards of being trained and employed as peer specialists extends beyond financial remuneration.

Four main themes emerged as participants described the impact the HCPS program had on their own recovery. First, almost all the participants endorsed the program by highlighting its role with improving their self-confidence and self-esteem. Graduating from the program was symbolic in their own recovery in demonstrating to themselves and others that they were capable of completing a rigorous training program. Other authors using quantitative (e.g., Johnston et al., 2012; Salzer et al., 2013) and qualitative methods (Moran et al., 2012) found similar results.

Second, participants described the training as having increased their empathy towards others with SMI. Several participants acknowledged their own stigma towards others with SMI, and how the training transformed their understanding and empathy to others with different variants of SMI. Moran et al. (2012) found similar results with participant's attributing growth and spiritual wellness to their training and employment as peer specialists.

Third, participants endorsed the program for having normalized their experience, and for having ended the isolation they felt early in their own recovery. As highlighted in this study, none of the participants had received formal peer support services in traditional mental health service settings. However, several participants actively participated in various self-help and mutual aid groups prior to and after certification. Almost all endorsed peer support in helping

themselves to recognize and appreciate that they were not alone and that others in the community understand the challenges and opportunities of living with a SMI. Participants also described having established a bond with others in their cohort. They also described having felt a sense of camaraderie and safety with other peer specialists. Bonding and connectedness to others peer specialists was not unique to this study (see Moran et al., 2012).

Fourth, participants attributed the program to broadening their perspectives and understanding of people, situations, and events. Previous studies have not identified this benefit theme. Participants also credited the program to helping them actively listen to others. Several participants reiterated how beneficial it was for them to learn and apply this skill when helping others move forward in their own recovery. It became clear throughout the study that participants positively endorsed this aspect of the training.

Study Limitations

This study used qualitative methods which cannot be generalized and only reflects the perspective and experiences of those interviewed. It is possible that if I were to have conducted this study at a different time with different HCPSs I may have found different results. Further, I believe that the proximity of time from when participants graduated may have yielded different results and insights. My decision to not include demographic information prevented me from examining the multidimensionality and intersectionality of other roles (e.g., gender, ethnicity) participants have and whether these roles potentially influenced or impacted their experiences and perspectives.

Other limitations included my choice to not interview mental health service users who separated from the program for various reasons (i.e., the forgotten), and not asking participants whether the lack of employment opportunities in Hawaii negatively impacted their own or their

classmate's recovery. Other areas that would have improved this study was having asked about their use of mental health services prior to and after having been credentialed. These are potential areas for further exploration and inquiry.

Another limitation of this study was not interviewing mental health administrators and clinicians in mental health service settings. It became clear early on this study that organizational culture and context was a barrier to successfully integrating HCPSs. It would have been helpful to compare and contrast their perspectives to the participants to better understand the nuances of implementation that may be context specific. Chinman et al (2017) identified that use of only the peer specialist viewpoint is a shortcoming in the literature that has examined the barriers and facilitators to implementing peer specialists in traditional mental health service settings.

Implications for Policy

Few studies have examined the impact peer specialist training programs have on mental health service users who are unemployed or working in other industries (Ahmed & Buckley, 2014; Ahmed et al., 2015; Salzer et al., 2013). The potential benefits of being trained as a peer provider for these individuals are less understood and less discussed. The explicit training in recovery may help individuals not interested in employment move forward in their own recovery. This implication could also potentially explain why so many HCPSs are unemployed.

Silver and Nemec (2015), suggest that "peer specialist certification programs should parallel other behavioral health service providers credentialing programs" (p. 290). As highlighted earlier, peer specialist programs across the nation vary in content, length, format, quality, and rigor (Silver & Nemec, 2015). Further, the programs vary greatly in terms of their eligibility requirements. In 2017, over much protest (Davidow, 2017), Mental Health America (2017) launched its national peer specialist certification credential to designate "advanced" peer

specialists from others. In absence of any standards to regulate this industry, commodification of disability will continue to exploit, marginalize, and exclude people with SMI.

Implications for Social Work Practice

Social work has long been involved in the provision of behavioral health services in a variety of inpatient and outpatient service settings for people with SMI and co-occurring SMI and substance use disorders. Although many in the mental health system endorse recovery as the overarching philosophy of care in behavioral health, the medical model continues to dominate the literature, research, terminology, nomenclature, and clinical practice for assessing, diagnosing, and treating mental disorders (Adame & Knudson, 2007). Loumpa (2012) highlights "social workers have often been among those who challenged the medical model by adopting the strengths perspective and concept of empowerment" and that social work values align with recovery-oriented practices and principles (p. 54).

The social work profession clearly articulates its commitment to social justice as outlined in the Code of Ethics for the National Association of Social Workers (NASW; 2017). According to the NASW (2017):

> Social workers challenge social injustice. Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people (p.5).

Social work continues to make great contributions to the design and delivery of mental health services across different systems of care, and efforts to implement and sustain per support are aligned with the profession's purpose and code of ethics (Loumpa, 2012). Efforts may include educating and orienting healthcare professionals and other social service providers to the role

and value of peer support. None of the participants in this study were referred to or received peer support services while receiving treatment in traditional mental health service settings. Introducing and actively involving peer providers in traditional mental health service settings promotes mental health service users' involvement in their own recovery and treatment. Peer providers are "experts by experience" and have demonstrated the invaluable role they have in facilitating recovery for others (Loumpa, 2012, p. 56).

Davidson (2014) warns that as the discipline grows, so does the possibility of exploitation of peer providers by administrators who see the potential of asserting an agenda of delivering unhelpful services that were once provided by professional staff. Thus, peer providers and their employing agencies may benefit from regularly reviewing and reflecting on the dangers of peer drift (i.e., transitioning from a recovery-oriented role to a medical treatment role; Chinman, Henze & Sweeney, n.d.). Chinman et al (2017) warns that peer specialists in traditional mental health service settings may conform to more traditional provider roles when employed in these types of agencies. Social work may take the lead in educating peer specialists and healthcare professionals to recognize the potential for peer drift, and to create safe, supportive practices that support peer specialists in returning to their unique role and practicing within their scope of expertise if drift has occurred.

The majority of adults with SMI do want to work; yet, only about 15% are actively employed (Drake et al., 2016). In a recent study that examined mental health professional perspectives on employment for adults with SMI, the authors found that participants viewed employment and financial self-sufficiency as of little relevance to their client's recovery (Costa et al., 2017). Three participants in this study identified mental health professionals by name that encouraged and supported them to apply to the HCPS program or consider other types of

employment within the system. Social workers are in a position to advocate and remind others of the importance of employment and recovery. Further, social workers may consider identifying and advocating for policies (e.g., Medicaid Buy-In Program) that remove barriers preventing people with SMI from returning to work or entering the competitive employment market.

Implications for Future Research

As highlighted in this and other studies, the implementation of peer support services in traditional mental health service settings across the nation has not been without challenges (Davis, 2015; Vandewalle, Debyser, Beeckman, Vandecasteele, Hecke, & Verharghe, 2016). Chinman et al. (2017) highlights the dearth of literature that identifies factors that facilitate or hinder the introduction, implementation, optimal utilization (Davis & Pilgrim, 2015), and sustainability of peer providers in traditional mental health service settings. Future research should examine barriers and facilitators to implementation (Chinman et al., 2017).

Another potential area for examination is identifying how peer specialist trainings across the United States prepare mental health services users for employment. No study has examined and compared the format and curriculum of peer specialist trainings across the nation to identify potential best practices in preparing peer providers to work in various types of behavioral health service settings.

The present study expands current knowledge of peer specialists' perceptions and experiences of barriers to implementation of peer specialists in Hawaii's traditional mental health service settings. The study also identified unique insights into potential motivation factors for Hawaii's mental health service users applying to the HCPS program. In addition, the study identified perceived benefits by individuals who chose to become peer specialists. The findings of this study are consistent with benefits reported in other studies (Moran et al., 2012; Mowbray

et al., 1998; Salzer & Shear, 2002); however, this study identified an additional benefit theme (i.e., broadening perspectives) not described in the literature. Collectively, these benefits were referenced as transformative factors in the participants' lives. In addition, participants also identified systemic inequalities and organizational barriers that have hindered the implementation of the HCPS program.

REFERENCES

Adame, A. L. & Knudson, R. M. (2007). Beyond the counter-narrative: exploring the alternative narratives of recovery from the psychiatric survivor movement. *Narrative Inquiry, 17*(2), 157 - 178.

Ahmed, A. O. & Buckley, P.F. (2014). Review tempers expectations for peer-led services but further studies are required. *Evidence Based Mental Health, 17*(4), 123. doi:10.1136eb-2014-101802

Ahmed, A. O., Hunter, K. M., Mabe, A. P., Tucker, S. J. & Buckley, P. F. (2015). The professional experiences of peer specialists in the Georgia Mental Health Consumer Network. *Community Mental Health Journal, 51*, 424 – 436. doi: 10.1007/s15097-015-9854-8

Alabama Department of Mental Health. (n.d.). *Office of consumer relations.* Retrieved from http://www.mh.alabama.gov/MI/consumers.aspx

Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act of 1992, Pub. L. No. 102-321, §1912(c)(1), 106 Stat. 323 (1992).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

23.

Americans with Disabilities Act of 1990, Pub. L. No. 101-336, § 2, 104 Stat. 328 (1991).

Appalachian Consulting Group. (2006a). *Georgia certified peer specialist project: facilitator's guide*. Cleveland, GA: Author

Appalachian Consulting Group. (2006b). *Peer specialist/peer support training – participant's manual.* Cleveland, GA: Author.

Asad, S. & Chreim, S. (2016). Peer support providers' role experiences on interprofessional mental health care team: a qualitative study. *Community Mental Health Journal, 52*, 767 – 774. Doi: 10.1007/s10597-015-9970-5

Ashcroft, L., Campbell, N., & Sanchez, J.D. (2014, September 18). Why should you hire peer specialists/recovery coaches [Webinar]. In *Substance abuse and Mental Health Services Administration's Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Webinars Series.* Retrieved from https://center4si.adobeconnect.com/_a966410469/p70fdpufhs8/?launcher=false&fcsContent=true&pbMode=normal

Baillargeon, J., Hoge, S. K., & Penn, J. V. (2010). Addressing the challenge of community reentry among released inmates with serious mental illness. *American Journal of Community Psychology, 46*, 361 – 375. doi: 10.1007/s10464-010-9345-6

Barnes, C. & Mercer, G. (2003). *Disability*. Malden, MA: Blackwell Publishers Inc.

Barnes, C., Mercer, G., & Shakespear, T. (1999). *Exploring disability: a sociological introduction.* Malden, MA: Blackwell Publishers Inc.

Bayes, M. & Neill, T. K. (1978). Problems for professionals in mental health services. *Administration and Policy in Mental Health And Mental Health Services Research, 6*(2), 133 – 146.

Bazeley, P. & Jackson, K. (2013). *Qualitative data analysis with NVIVO* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Beckett, A. E. (2006). *Citizenship and vulnerability: disability and issues of social and political engagement.* New York, NY: Palgrave Macmillan.

Bond, G. R., Xie, H., Drake, R. E. (2007). Can SSDI and SSI beneficiaries with mental illness

benefit from evidence-based supported employment? *Psychiatric Services, 58*(11), 1412 – 1420.

Boust, S. J., Kuhns, M. C., & Studer, L. (2005). Assertive Community Treatment. In C. E. Stouts & R. A. Hayes (Eds), *Evidence-based practice: methods, models, and tools for mental health professionals* (pp. 31-56). Hoboken, NJ: John Wiley & Sons, Inc.

Brookfield, S. D. (2005). *The power of critical theory for adult learning and teaching.* New York, NY: Open University Press.

Cabral, L., Strother, H., Muhr, K., Sefton, L., & Savageau, J. (2014). Clarifying the role of the mental health peer specialist in Massachusetts, USA: Insights from peer specialists, supervisors, and clients. *Health and Social Care in the Community, 22*(1), 104-112. doi:10.111/hsc.12072

Cameron, D. & McGowan, P. (2013). The mental health social worker as a transitional participant: actively listening to 'voices' and getting into the recovery position. *Journal of Social Work Practice, 27*(1), 21-32. doi:10,1080/02650533.2012.732047.

Carlson, L. S., Rapp, C. A., & McDiarmid, D. (2001). Hiring consumer providers: barriers and alternative solutions. *Community Mental Health Journal, 37*(3), 199 – 213.

Carpenter, J. (2002). Mental health recovery paradigm: implications for social work. *Health & Social Work, 27*(2), 86 -94.

Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations. (2007). *Letter to State Medicaid directors* (No. SMDL #07-011). Baltimore, MD: United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations. Retrieved from:

http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf

Centers for Medicare and Medicaid Services, Division of Medicaid and Children's Health Operations (2013). Letter to Hawaii's State Medicaid director approving state plan amendment 13-004. Baltimore, MD: United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, Division of Medicaid and Children's Health Operations. Retrieved from https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/HI/HI-13-004-MSPA.pdf

Chamberlin, J. (1978). *On our own: patient-controlled alternatives to the mental health system.* New York, NY: Hawthorn Books.

Chamberlin, J. (1984). Speaking for ourselves. An overview of the ex-psychiatric inmates movement. *Psychiatric Rehabilitation Journal, 8,* 56 – 63.

Chamberlin, J. (1990). The ex-patients' movement: where we've been and where we're going. *Journal of Mind and Behavior, 11*(3), 323 – 336.

Chapman, S., Blash, L., & Chan, K. (2015). *The peer provider workforce in behavioral health: a landscape analysis.* San Francisco, CA: University of California at San Francisco Health Workforce Research Center on Long-Term Care.

Charmaz, K. (2005). Grounded theory in the 21st century: applications for advancing social justice issues. In N. K. Denzin & Y. Lincoln (Eds.), *Strategies of qualitative inquiry* (3rd ed., pp. 507-535). Thousand Oaks, CA: SAGE Publications.

Charmaz, K. (2006). *Constructing grounded theory: a practical guide through qualitative analysis.* Thousand Oaks, CA: SAGE Publications.

Charmaz, K. (2008). Grounded theory as an emergent method. In S.N. Hesse-Biber & P. Leavy

(Eds.), *Handbook of emergent methods* (pp. 155-170). New York, NY: Guilford Press.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Thousand Oaks, CA: SAGE Publications.

Charmaz, K., Thornberg, R., & Keane, E. (2017). Evolving grounded theory and social justice theory. In N. K. Denzin & Y. S. Lincoln (Eds.). *The SAGE handbook of qualitative research* (5th ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Shoma Ghose, A., Swift, A., & Delphin-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illnesses: assessing the evidence. *Psychiatric Services, 65*(4), 429-441. doi:10.1176/appi.ps.201300244.

Chinman, M., Henze, K., & Sweeney, P. (n.d.). Peer specialist toolkit: implementing peer support services in the VHA. Retrieved from https://www.mirecc.va.gov/visn4/docs/Peer_Specialist_Toolkit_FINAL.pdf

Chinman, M., Lucksted, A., Green, R., Davis, M., Losonczy, M., Sussner, B., & Martone, L. (2008). Early experiences of employing consumer-providers in the VA. *Psychiatric Services, 59*(11), 1315 – 1321.

Chinman, M. J., McInnes, D. K., Eisen, S., Ellison, M., Farkas, M., Armstrong, M., & Resnick, S. G. (2017). Establishing a research agenda for understanding the role and impact of mental health peer specialists. *Psychiatric Services, 68*(9), 955- 057. doi: 10.1176/appi.ps/201700054

Chinman, M.J., Rosenheck, R., Lam, J., & Davidson, L. (2000). Comparing consumer and nonconsumer provided case management services for homeless persons with serious mental illness. *The Journal of Nervous and Mental Disease, 188*(7), pp. 446-453.

Chinman, M., Salzer, M., & Obrien-Mazza, D. (2012). National survey on implementation of peer specialists in the VA: implications for training and facilitation. *Psychiatric Rehabilitation Journal, 35* (6), 470 - 473. doi:10.1037/h0094582

Civil Rights of Institutionalized Persons Act of 1980, 42 U.S.C. §1997

Clarke, G. N., Herinckx, H. A., Kinney, R. F., Paulson, R. I., Cutler, D. L., Lewis, K., & Oxman, E. (2000). Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with a serious and persistent mental illness: findings from a randomized trial of two ACT programs vs. usual care. *Mental Health Services Research, 2*(3), 155-164. doi: 10.1023/A:101014826867

Cook, J. A. (2006). Employment barriers for persons with psychiatric disabilities: update of a report for the President's Commission. *Psychiatric Services, 57*(10), 1391 – 1405.

Corbin, J. & Strauss, A. (2015). *Basics of qualitative research: techniques and procedures for developing grounded theory* (4th ed.). Thousand, Oaks, CA: SAGE Publications Inc.

Corrigan, P. W., Mueser, K. T., Bond, G. R., Drake, R. E., & Solomon, P. (2008). *Principles and practices of psychiatric rehabilitation: an empirical approach.* New York, NY: Guilford Press

Corrigan, P. W. & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1* (1), 16 - 20.

Costa, M., Baker, M., Davidson, L., Giard, J., Guillorn, L., Gonzalez, A. G., Weitz, D., & O'Connell, M. (2017). Provider perspectives on employment for people with serious mental illness. *International Journal of Social Psychiatry, 63*(7), 632 – 640. doi: 10.1177/0020764017722569

Craig, T., Doherty, I., Jamieson-Craig, R., Boocock, A., & Attafua, G. (2004). The consumer-

employee as a member of mental health assertive outreach team. I. Clinical and social outcomes. *Journal of Mental Health, 13*(1), 59-69. doi: 10.1080/09638230410001654567

Craig, T., Doherty, I., Jamieson-Craig, R., Boocock, A., & Attafua, G. (2004). The consumer-employee as a members of a mental health assertive outreach team. II. Impressions of consumer-employees and other team members. *Journal of Mental Health, 13*(1), 71-81. Doi: 10.1080/09638230410001654567

Creswell, J. W. (2009). *Research design: qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications Inc.

Creswell, J. W. (2013). *Qualitative inquiry and research design: choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications Inc.

Creswell, J. W. (2016). *30 essential skills for the qualitative researcher.* Thousand Oaks, CA: Sage Publications Inc.

Creswell, J. W. & Miller, D. W. (2000). Determining validity in qualitative inquiry. *Theory into Practice, 39*(3), 124 – 130.

Cronise, R., Teixeira, C., Rogers, E. S., & Harrington, S. (2016). The peer support workforce: results of national survey. *Psychiatric Rehabilitation Journal, 39*(3), 211- 221. doi: http://dx.doi.org/10.1037/prj0000222

Daniels, A. S., Bergeson, S., Fricks, L., Ashenden, P., & Powell, I. (2012). Pillars of peer support: advancing the role of peer support specialists in promoting recovery. *Journal of Mental Health Training, Education, and Practice*, *7*(2), 60–69. doi:10.1108/17556221211236457

Davidow, S. (2017). The downfall of peer support: MHA and national certification. Retrieved

from https://www.madinamerica.com/2017/04/downfall-peer-support-mha-national-certification/

Davidson, L. (2014). Peer support in mental health: exploitive, transformative, or both? Retrieved from https://www.madinamerica.com/2014/09/peer-support-mental-health-exploitive-transformative/

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry, 11*(2), 123 – 128.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: a report from the field. *Schizophrenia Bulletin*, *32*(3), 443 – 450. doi:10.1093/schbul/sbj043

Davidson, L., Roe, D., Andres-Hyman, R., & Ridgway, P. (2010). Applying stages of change models to recovery from serious mental illness: contributions and limitations. *Israel Journal of Psychiatry and Related Sciences, 47*(3), 213 – 221.

Davidson, L., Shahar, G., Stayner, D. A., Chinman, M. J., Rakfeldt, J., & Kraemer Tebes, J. (2004). Supported socialization for people with psychiatric disabilities: lessons learned from a randomized controlled trial. *Journal of Community Psychology, 32*(4), 453-477. doi:10.1002/jcop.20013

Davis, J. K. (2015). Supervision of peer specialists in community mental health centers: practices that predict role clarity. *Social work in mental health, 13*(2), 145 – 158. doi: 10.1080.15332985.2013.801390

Davis, J. K. & Pilgrim, S. I. (2015). Maximizing utilization of peer specialists in community

mental health: the next step in implementation. *Journal of Psychosocial Rehabilitation in Mental Health, 2*(1), 67 – 74. doi: 10.1007/s40737-015-0026-5

Davis, K. (2008). New federalism, new freedom, and states' rights: the uncertain and fragmented direction of public mental health policy in the United States. In I. Colby, K. Sowers, & C. Dulmus (Eds.), *Comprehensive Handbook of Social Work and Social Welfare: Social Policy and Policy Practice* (Vol. 4, 145 – 176), Hoboken, NJ: John Wiley & Sons, Inc.

Davis, L., Fulginiti, A., Kriegel, L., & Brekke, J. S. (2012). Deinstitutionalization? Where have all the people gone? *Current Psychiatry Reports, 14,* 259 – 269. doi: 10.1007/s/11920-012-027-1

Deegan, P. E. (1997). Recovery and empowerment for people with psychiatric disabilities. *Social Work in Health Care, 25(*3), 11-24. doi:10.1300/J010v25n03_02

Demblin, B. P., Chen, D. T., & Vachon, L. (1999). Life expectancy and causes of death in a population treated for serious mental illness. *Psychiatric Services, 50,* 1036 – 1042. doi:http://dx.doi.org/10.1176/ps.50.8.1036

Department of Housing and Urban Development. (2017). *HUD's 2017 continuum of care homeless assistance programs: homeless population and subpopulations.* Retrieved from https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2017.pdf.

Devlin, R., & Pothier, D. (2006). Toward a critical theory of dis-citizenship. In D. Pothier, & R. Devlin (Eds.), *Critical disability theory: essays in philosophy, politics, policy, and law (pp.1 - 22).* Toronto: UBC Press.

Dey, I. (1999). *Grounding grounded theory: guidelines for qualitative inquiry.* San Diego, CA: Academic Press.

Ditton, P. M. (1999). *Mental health and treatment of inmates and probationers.* US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Retrieved from http://www.bjs.gov/index.cfm?ty=pbdetail&iid=787

Dixon, L., Krauss, N., & Lehman, A. (1994). Consumers as service providers: the promise and challenge. *Community Mental Health Journal, 30*(6), 615- 625.

Drake, R. E., Bond, G. R., Goldmna, H. H., Hogan, M. F., & Karakus, M. (2016). Individaual placement and support services boost employment for people with serious mental illnesses, but funding is lacking. *Health Affairs, 35*(6), 1098 – 1105. doi: 10.1377/hlthaff.2016.0001

Dunn, E. C., Wewiorski, N. J., & Rogers, E. S. (2008). The meaning and importance of employment to people in recovery from serious mental illness: results of a qualitative study. *Psychiatric Rehabilitation Journal, 32*(1), 59-62. doi: 10.2975/32.1.2008.59.62

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science, 196*(4286), 129-136.

Erickson, W., Lee, C., & von Schrader, S. (2016). *2016 disability status report: United States.* Ithaca, NY: Cornell University Yang-Tan Institute on Employment and Disability. Retrieved from http://www.disabilitystatistics.org/StatusReports/2016-PDF/2016-StatusReport_US.pdf?CFID=6321256&CFTOKEN=be584eeca113aac7-E380BF92-CCF9-7323-32074B29213F5435

Felton, C. J., Stastny, P., Shern, D. L., Blanch, A., Donahue, S. A., Knight, E., & Brown, C. (1995). Consumers as peer specialists on intensive case management teams: impact on client outcomes. *Psychiatric Services, 46*(10), pp. 1037- 1044.

Feucht, T. E. & Gfroerer, J. (2011). *Mental and substance use disorders among adult men on*

probation or parole: some successes against a persistent challenge. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality.

Frese, F. J., & Davis, W. W. (1997) The consumer-survivor movement, recovery, and consumer professionals. *Professional Psychology, 28*(3), 243-245.

Frese, F. J., Knight, E.L., & Saks, E. (2009). Recovery from Schizophrenia: with views of psychiatrists, psychologists, and others diagnosed with this disorder. *Schizophrenia Bulletin, 35*(2), 370 – 380. doi: 10.1093/schbul/sbn175

Frese, F. J. & Myrick, K. J. (2010). On consumer advocacy and the diagnosis of mental disorders. *Professional Psychology: Research and Practice, 41*(6), 495 – 501. doi: 10.1037/a0021527

Gates, L. B. & Akabas, S. H. (2007). Developing strategies to integrate peer providers into the staff of mental health agencies. *Administration and Policy in Mental Health & Mental Health Services Research, 34,* 293 – 306. doi: 10.1007/s10488-006-0109-4

Georgia Certified Peer Specialist Project. (2003). Georgia certified peer specialist project. Retrieved from http://www.gacps.org/Home.html

Gerard, J. B. (1999). The medical model of mental illness: its application to the insanity defense. *International Journal of Law and Psychiatry, 20*(1), 65- 78.

Ghaemi, S. N. (2003). *The concepts of psychiatry: a pluralistic approach to the mind and mental illness.* Batimore, MD: Johns Hopkins University Press.

Glasser, B.G. & Strauss, A.L. (1967). *The discovery of grounded theory: strategies for qualitative research.* New Brunswick, NJ: Aldine Transaction.

Gochros, S. L. (1994). *"Reinventing" governance of Hawaii's public mental health delivery*

system – problems, options, and possibilities (Report No. 5, 1994). Honolulu, HI: Hawaii State Legislative Reference Bureau.

Goldman, H. H. & Grob, G. N. (2006). Defining 'mental illness' in mental health policy. *Health Affairs, 25*(1), 737 – 749. doi: 10.1377/hlthaff.25.3.737

Greenberg G.A. & Rosenheck, R.A. (2010). Correlates of past homelessness in the National Epidemiological Survey on Alcohol and Related Conditions. *Administration and Policy in Mental Health* (37), 357–366.

Grob, G. N. (2005). Public policy and mental illnesses: Jimmy Carter's presidential commission on mental health. *Milbank Quarterly, 83*(3), 425 – 456. doi: 10/1111/j.1468-0009.2005.00408x

Hanson-Mayer, G. (2006). *Final evaluation of the Adult Mental Health Division* (Report No. 12). In United States of America vs. State of Hawaii. Honolulu, HI: U.S. District Court.

Harding, C. M. (2005). Changes in schizophrenia across time: paradoxes, patterns, and predictors. In L. Davidson, C. Harding, & L. Spaniol (Eds.) *Recovery from severe mental illnesses: research evidence and implications for practice* (Vol 1, pp. 27-48. Boston, MA: Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences.

Hawaii Administrative Rules, Mental Health and Substance Abuse Systems, 11-175-02

Hawaii State Department of Health, Adult Mental Health Division (2003, February). *AMHD news: community plan edition.* Honolulu, HI: Adult Mental Health Division.

Hawaii State Department of Health, Adult Mental Health Division (2012). *Hawaii certified peer specialist program: guidelines, standards, and procedures.* Retrieved from health.hawaii.gov/amhd/files/2013/06/HCPS-Handbook.pdf

Hawaii State Department of Health, Adult Mental Health Division (2014). *Hawaii certified peer specialist training manual 2014.* Honolulu, HI: Hawaii State Department of Health, Adult Mental Health Division.

Helmchen, H. (2013). Different conceptions of mental illness: consequences for the association with patients. *Frontiers in Psychology (4),* 1 – 5. doi: 10.3389/fpsyg.2013.00269

Hiranandani, V. (2005). Towards a critical theory of disability in social work. *Critical Social Work, 6*(1). Retrieved from http://www1.uwindsor.ca/criticalsocialwork/towards-a-critical-theory-of-disability-in-social-work

Hire Abilities Hawaii. (2016). *The Medicaid buy-in program.* Retrieved from http://www.hireabilitieshawaii.org/the-medicaid-buy-in-program/

Hogan, M. F. (2002). Spending too much on mental illness in all the wrong places. *Psychiatric Services, 53*(10), 1251 – 1252. doi: http:dx.doi.org/10.1176.aooi.ps.53.10.1251

Hoge, M. A., Paris, M., Adger, H., Collins, F. L., Foinn, C. V., Fricks, L., Gill, K. J., Haber, J., Hansen, M., Ida, D. J., Kaplan, L., Northey, W. F., O'Connell., M. J., Rosen, A. L., Zebulon, T., Tondora, J., & Young, A. S. (2005). Workforce competencies in behavioral health: an overview. *Administration and Policy in Mental Health, 22*(5), 593-631. doi:10.1007/s10488-005-3259-x

Hosking, D. L. (2008). Critical disability theory. Paper presented at the 4th Biennial Disability Studies Conference, Lancaster, United Kingdom. Retreived from http://www.lancaster.ac.uk/fass/events/disabilityconference_archive/2008/papers/hosking2008.pdf

Hutchinson, D. S., Anthony, W. A., Ashcroft, L., Johnson, E., Dunn, E. C., Lyass, A., & Rogers,

E. S. (2006). The personal and vocational impact of training and employing people with psychiatric disabilities as providers. *Psychiatric Rehabilitation Journal, 29*(3), 205 – 213.

Insel, T. R. (2008). Assessing the economic costs of serious mental illness. *The American Journal of Psychiatry*, *165*(6), 663-665. doi:10.1176/appi.ajp.2008.08030366

Jacobson, N. (2001). Experiencing recovery: a dimensional analysis of recovery narratives. *Psychiatric Rehabilitation Journal, 24*(3), 248 – 256.

Jobe, T. H. & Harrow, M. (2005). Long term outcomes of patients with schizophrenia: a review. *Canadian Journal of Psychiatry, 50*(14), 892 – 900.

Johnson, G., Magee, C., Mary, M., Furlong-Norman, K., Rogers, E., & Thompson, K. (2014). Personal and societal benefits of providing peer support: a survey of peer support specialists. *Psychiatric Services, 65*(5), 678 – 680.

Johnstone, D. (2001). *An introduction to disability studies* (2nd ed.). London, United Kingdom: David Fulton Publishers Limited.

Jones, D. R., Macias, C., Barreira, P. J., Fisher, W. H., Hargreaves, W. A., & Harding, C. M. (2004). Prevalence, severity, and co-occurrence of chronic physical health problems of person with serious mental illness. *Psychiatric Services, 55,* 1250 – 1257. doi: http://dx.doi.org/10.1176/appi.ps.55.11.1250.

Kaiser Family Foundation (2015). *Medicaid eligibility through buy-in programs for working people with disabilities.* Retrieved from https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Kaufman, L., Brooks, W., Bellinger, J., Steinley-Bumgarner, M., & Stevens-Manser, S. (2014).

Peer specialist training and certification programs: a national overview. Retrieved from Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin website: http://sites.utexas.edu/mental-health-institute/files/2014/07/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview-2014-Update.pdf

Kaufman, L., Kuhn, W., & Stevens-Manser, S. (2017). Peer specialist training and certification programs: a national overview. Retrieved from Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin: http://sites.utexas.edu/mental-health-institute/files/2017/01/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview-2016-Update-1.5.17.pdf

Kemp, V. & Anderson, A. R. (2012). Challenges faced by mental health peer support workers: peer support from the peer supporter's point of view. *Psychiatric Rehabilitation Journal, 35*(4), 337 – 340. doi: http://dx.doi.org/10.2975/35.4.2012.337.340

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., Manderscheid, R. A., Rosenheck, R. A., Walter, E. E., & Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research, 36*(6), 987-1007.

Kincheloe, J. L. & McLaren, P. (2000). Rethinking critical theory in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 279 - 314). Thousand Oaks, CA: Sage Publications, Inc.

Kincheloe, J. L. & McLaren, P. (2005). Rethinking critical theory in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (3rd ed., pp. 279 - 314). Thousand Oaks, CA: Sage Publications, Inc.

Kruger, A. (2000). Schizophrenia: recovery and hope. *Psychiatric Rehabilitation Journal, 24*(1), 29-37.

Kuhn. W., Bellinger, J., Stevens-Manser, S. & Kaufman, L. (2015). Integration of peer specialists working in mental health settings. *Community Mental Health Journal, 51*, 453 – 458. doi: 10.1007/s10597-015-9841-0

Lalvani, P. & Polvere, L. (2013). Historical perspectives on studying families of children with disabilities: a case for critical research. *Disability Studies Quarterly, 36*(4).

Landers, G. & Zhou, M. (2011). An analysis of relationships among peer support, psychiatric hospitalization, and crisis stabilization. *Community Mental Health Journal, 47*(1), 106 – 112. doi: 10.1007/s10597-009-9218-3

Landers, G. & Zhou, M. (2014). The impact of Medicaid peer support utilization on cost. *Medicare & Medicaid Research Review, 4*(1), E1 – E17. doi:http://dx.doi.org/10.5600/mmrr.004.01.a04

Linton, S. (1998). *Claiming disability: knowledge and identity.* New York, NY: New York University Press.

Loumpa, V. (2012). Promoting recovery through peer support: possibilities for social work practice. *Social Work in Health Care, 51,* 53- 65. doi: 10.1080/00981389.2011.622667

Luciano, A. & Meara, E. M. (2014). The employment status of people with mental illness: National survey data from 2009 – 2010. *Psychiatric Services, 65*(10), 1201 – 1209. doi: 10.1176/appi.ps.201300335

Mancini, M.A., Hardiman, E.R., & Lawson, H.A. (2005). Making sense of it all: consumer providers' theories about factors facilitating and impeding recovery from psychiatric disabilities. *Psychiatric Rehabilitation Journal, 29*(1), 48-55.

May, T. (2004). Critical theory. In M. S. Lewis-Beck, A. Bryman, & T. Futing Liao (Eds.), *The SAGE Encyclopedia of Social Science Research Methods* (Vol. 1, 223 – 224). Thousand Oaks, CA: SAGE Publications.

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: a theoretical perspective. *Psychiatric Rehabilitation Journal, 25*(2), 134 – 141.

Mechanic, D., Bider, S., & McAlpine, D. D. (2002). Employing persons with serious mental illness. *Health Affairs, 21*(5), 242-253. doi:10.1037/hlthaff.21.5.242

Mental Health America (2017). MHA national certified peer specialist certification. Retrieved from http://www.mentalhealthamerica.net/mha-national-certified-peer-specialist-certification-get-certified

Mental Health Services Act, 42 U.S.C. § 300x-3 (1986).

Merriam, S. B. & Tisdell, E. J. (2016). *Qualitative research: a guide to design and implementation* (4th ed.). San Francisco, CA: Jossey- Bass.

Miller, J. E. & Prewitt, E. (2012). Reclaiming lost decades: The role of state behavioral health agencies in accelerating the integration of behavioral healthcare and primary care to improve the health of people with serious mental illness. Retrieved from http://www.nasmhpd.org/sites/default/files/Reclaiming%20Lost%20Decades%20Full%20Report.pdf

Miller, W. R. & Rollnick, S. (2013). *Motivational interviewing: helping people change* (3rd ed.). New York, NY: Guilford Press.

Miyamoto, Y. & Sono, T. (2012). Lessons from peer support among individuals with mental health difficulties: a review of the literature. *Clinical Practice & Epidemiology in Mental Health, 8*, 22 -29.

Moll, S., Holmes, J., Geronimo, J., & Sherman, D. (2009). Work transitions for peer support providers in traditional mental health programs: unique challenges and opportunities. *Work, 32*, 449 – 458. doi: 10.3233/WOR-2009-0893

Moran, G. S., Russinova, Z., Gidugu, V., Yeon Yim. J., & Sprague, C. (2012). Benefits and mechanisms of recovery among peer providers with psychiatric illnesses. *Qualitative Health Research, 22*(3), 304 – 319. doi: 10.1177/1049732311420578

Moran, G. S., Russinova, Z., Yeon Yim. J., & Sprague, C. (2014). Motivations of persons with psychiatric disabilities to work in mental health peer services: a qualitative study using self-determination theory. *Journal of Occupation Rehabilitation, 24*, 32 – 41. doi: 10.007/s/10926-013-9440-2

Morley, C. (2003). Towards critical social work practice in mental health: a review. *Journal of Progressive Human Services, 14*(1), 61 – 84. doi: 10.1300/J059v14n01_05

Mowbray, C. T., Moxley, D. P., Collins, M. E. (1998). Consumers as mental health providers: first-person accounts of benefits and limitations. *Journal of Behavioral Health Services & Research, 25*(4), 397 – 411.

Mowbray, C., Moxley, D., Thrasher, S., Bybee, D., & Harris, S. (1996). Consumers as community support providers: issues created by role innovation. *Community Mental Health Journal, 32*(1), 47-67.

Mueser, K. T., Corrigan, P. W., Hilton D. W., Tanzman, B., Schaub, A., Gingerich, S., Essock, S. M., Tarrier, N., Morey, B., Vogel-Scibilia, S., & Herz, M. L. (2002). Illness management and recovery: a review of the research. *Psychiatric Services, 53*(10), 1272 – 1284.

Munn-Giddings, C. & McVicar, A. (2006). Self-help groups as mutual support: what do carers

value? *Health and Social Care in the Community, 15*(1), 26 – 34. doi: 10.1111/j.1365-2524.2006.00660.x

National Association of Social Workers (2017). *Code of ethics of the National Association of Social Workers.* Washington, DC: Author.

National Association of State Mental Health Program Directors (2006). *Morbidity and mortality in people with serious mental illness.* Retrieved from http://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

National Commission on Correctional Health Care. (2002). *The health status of soon-to-be released inmates: a report to Congress.* Retrieved from http://www.ncchc.org/filebin/Health_Status_vol_1.pdf

New Hampshire Department of Health and Human Services. (2010). *Office of consumer and family affairs.* Retrieved from http://www.dhhs.state.nh.us/dcbcs/bbh/ocfa.htm

O'Donnell, M., Parker, G., Proberts, M., Matthews, R., Fisher, D., Johnson, B., & Hadzi-Pavlovic, D. (1999). A study of client-focused case management and consumer advocacy: the community and consumers service project. *Australian and New Zealand Journal of Psychiatry, 33, 684*-693.

Oliver, M. (1998). Theories of disability in health practice and reseach. *BMJ, 317*, 1446 – 1449.

Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R.O., & Cook, J.A. (2007). An analysis of the definition and elements of recovery: a review of the literature. *Psychiatric Rehabilitation Journal, 31*(1), 9-22. doi: 10.2975/31.1.2007.9.22.

Osher, F., D'Amora, D. A., Plotkin, M., Jarrett, N., & Eggleston, A. (2012). *Adults with*

behavioral health needs under correctional supervision: a shared framework for reducing recidivism and promoting recovery. Washington, DC: Council on State Governments Justice Center, Criminal Justice/Mental Health Concensus Project.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: SAGE Publications.

Perkins, R., Buckfield. R., & Choy, D. (1997). Access to employment: a supported employment project to enable mental health service users to obtain jobs within mental health teams. *Journal of Mental Health, 6*(3), 307 – 318. doi: http://dx.doi.org/10.1080/09638239718842

Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S. E., Ryan, R., & Berends, L. (2013). Consumer-providers of care for adults clients of statutory mental health services. Cochrane *Database of Systematic Reviews, 3*, doi: 10.1002/14651858.CD004807.pub2

President's Commission on Mental Health. (1978). Report to the President from the President's Commission on Mental Health (Vol. 1). Washington, DC: U.S. Government Printing Office.

President's New Freedom Commission on Mental Health (2003). *Achieving the promise: transforming mental health care in America: final report* (DHHS Publication No. [SMA] 03-3832). Retrieved from http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf

Procknow, G., Rocco, T. S., & Munn, S. L. (2017). (Dis)ableing notions of authentic leadership through the lens of critical disability theory. *Advances in Developing Human Resources, 19*(4), 362 – 377. doi: 10.1177/1523422317728732

Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A., & Luty, J. (2009). A study of stigmatized attitudes towards people with mental health problems among health professionals. *Journal of Psychiatric and Mental Health Nursing*, *16*, 279 – 284.

Rapp, C. A. & Goscha, R. J. (2011). *The strengths model: a recovery-oriented approach to mental health services* (3rd ed.). New York, NY: Oxford University Press.

Reaume, G. (2002). Lunatic to patient to person: nomenclature in psychiatric history and the influence of patients' activism in North America. *International Journal of Law and Psychiatry, 25,* 405 – 426.

Reif, S., Braude, L., Russel Lyman, D., Dougherty, A. S., Daniels, A. S., Shoma Ghose, S., Salim, O., & Delphin-Rittmon, M. (2014). Peer recovery support for individuals with substance use disorders: assessing the evidence. *Psychiatric Services, 65*(7), 853-861. doi: 10.1176/appi.ps.201400047

Repper, J. & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health, 20*(4), 392 – 411. doi: 10.3109/09638237.2011.583947

Ridgway, P. (2001). ReStorying psychiatric disability: learning from first person recovery narratives. *Psychiatric Rehabilitation Journal, 24*(4), 335 – 343.

Rioux, M., & Fraser, V. (2006). Does theory matter? Exploring the nexus between disability, human rights and public policy. In D. Pothier, & R. Devlin (Eds.), *Critical disability theory: essays in philosophy, politics, policy, and law (pp.47 - 69).* Toronto: UBC Press.

Ritter, L. A. & Lampkin, S. M. (2012). *Community mental health.* Sudbury, MA: Jones & Bartlett Learning.

Rivera, J. J., Sullivan, A. M., & Stravos Valenti, S. (2007). Adding consumer-providers to

intensive case management: does it improve outcomes? *Psychiatric Services, 58*(6), 802-809.

Rocco, T. S. (2005). From disability studies to critical race theory: working towards critical disability theory. Paper presented at the 2005 Adult Education Research Conference, Athens, GA. Retrieved from http://newprairiepress.org/cgi/viewcontent.cgi?article=2685&context=aerc

Ruter, T. J. & Swarbrick, P. (2010). *Consumer involvement with state mental health authorities.* Retrieved from National Association of State Mental Health Program Directors website: http://www.nasmhpd.org//sites/default/files/Consumer%20Involvement%20with%20Persons%20with%20SMI%20Final%20Part%201...rev%282%29.pdf

Sabin, J. E. & Daniels, N. (2003). Strengthening the consumer voice in managed care: VII. The Georgia peer specialist program. *Psychiatric Services, 54*(4), 497-498.

Sagar, K. (2008). United States versus Hawaii – civil rights litigation clearinghouse. Retrieved from http://www.clearinghouse.net/detail.php?id=408

Salzer, M. S., Berkey, K., Dodson, J., Duckery, T., Rodgers, W., Rogers, J., Rogers, S., Simiriglia, C., Waddington, L., Whitecraft, J., & Leibfried, T. (2002). Consumer-delivered services as a best practice in mental health care delivery and the development of practice guidelines. *Psychiatric Rehabilitation Skills, 6*(3), 355 - 382.

Salzer, M. S., Darr, N., Calhoun, G., Boyer, W., Loss, R. E., Goessel, J., Schwenk, E., & Brusilovskiy, E. (2013). Benefits of working as a certified peer specialist: results from a statewide survey. *Psychiatric Rehabilitation Journal, 36*(3), 219-221. doi:10.1037/prj0000016

Salzer, M. S., Katz, J., Kidwell, B., Federici, M., & Ward-Colasante, C. (2009). Pennsylvania

certified peer specialist initative: training, employment and work satisfaction outcomes. *Psychiatric Rehabilitation Journal, 32*(4), 301 – 305. doi: 10.2975/32.4.2009.301.305.

Salzer, M. S., Schwenk, E., & Brusilovskiy, E. (2010). Certified peer specialist roles and activities: results from a national survey. *Psychiatric Services, 61*(5), 520 – 523.

Salzer, M. S., & Shear, S. L. (2002). Identifying consumer-provider benefits in evaluations of consumer-delivered services. *Psychiatric Rehabilitation Journal, 25*(3), 281-288.

Saunders, B., Kitzinger, J., & Kitzinger, C. (2015). Anonymising interview data: challenges and compromise in practice. *Qualitative Research, 15(5),* 616-632. doi: 10.1177/1468794114550439

Schmidt, L. T., Gill, K. J., Wison Pratt, C., & Solomon, P. (2008). Comparison of service outcomes of case management teams with and without a consumer provider. American *Journal of Psychiatric Rehabilitation, 11,* 310-329. doi:10.1080/15487760802186253

Schon, U. (2010). Recovery from severe mental illness, a gender perspective. S*candinavian Journal of Caring Sciences, 24*, 557 - 564. doi: 10.1111/j.1471-6712.2009.00748.x

Sells, D., Davidson. L., Jewel, C., Falzer, P. & Rowe, M. (2006). The treatment relationship in peer-based and regular case management for clients with severe mental illness. *Psychiatric Services, 57*(8), 1179- 1184.

Shah, P. & Mountain, D. (2007). The medical model is dead – long live the medical model. *British Journal of Psychology*, 191, 375-377. doi:10.1192/bjp.bp.107.037242

Sharfstein, S. S. & Dickerson, F. B. (2006). Psychiatry and the consumer movement. *Health Affairs, 25*(3), 734 – 736. doi: 10.1377/hlthaff.25.3.743

Schroeder, F. K. (2015). People with disabilities: the orphan minority. Paper presented at the 2015 Jacobus tebBroek Disability Law Symposium, San Diego, CA. Retrieved from

https://interwork.sdsu.edu/drupal/system/files/files/TheOrphanMinority_Schroeder.pdf

Sliver, J. & Nemec, P. B. (2016). The role of peer specialists: unanswered questions. *Psychiatric Rehabilitation Journal, 39*(3), 289 – 291. doi: http://dx.doi.org/10.1037/prj0000216

Sledge, W. H., Lawless, M., Sells, D., Wieland, M., O'Connell, M. J., & Davidson, L. (2011). Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. *Psychiatric Services, 62*(5), 541 – 544.

Smith, F.A.. and Bhattarai, S. (2008). *Persons served in community mental health programs and employment. DataNote Series, DataNote XVII*. Boston, MA: Institute for Community Inclusion.

Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal, 27*(4), 392 – 401.

Solomon, P. & Draine, J. (1995). The efficacy of a consumer case management team: 2 year outcomes of a randomized controlled trial. *Journal of Mental Health Administration, 22*(2), 135-146.

Solomon, P. & Draine, J. & Delaney, M.A. (1995). The working alliance and consumer case management. *Journal of Mental Health Administration, 22*(2), 126-134.

Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services, 60*(6), 761 – 765. doi: http://dx.doi.org/10.1176/ps.2009.60.6.761

Substance Abuse and Mental Health Services Administration. (2009). *What are peer recovery support services?* HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA's working*

definition of recovery: 10 guiding principles of recovery. HHS Publication No. PEP12-RECDEF. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2014). *Results from the 2013 national survey on drug use and health: mental health findings. NSDUH Series H-49.* HHS Publication No. (SMA) 14-4887. Rockville, MD. Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2015). *Behavioral health barometer: United States, 2014,* HHS Publication No. SMA 15-4895. Rockville, MD. Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2017). *Mental and substance use disorders.* Retrieved from https://www.samhsa.gov/disorders

Swain, J., French, S., & Cameron, C. (2003). *Controversial issues in a disabling society.* Philadelphia, PA: Open University Press.

Tomes. N. (2006). The patient as a policy factor: a historical case study of the consumer/survivor movement in mental health. *Health Affairs, 25*(1), 720-729.

United States Department of Labor, Bureau of Labor Statistics. (2018). 2018 Standard Occupational Classification System. Retrieved from https://www.bls.gov/soc/2018/major_groups.htm

United States Department of Health and Human Services (1999). *Mental health: a report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health.

Vandewalle, J., Debyser, B., Beeckman, D., Vandecasteele, T., Hecke, A. V., & Verharghe, S.

(2016). Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review. *International Journal of Nursing, 60,* 234 – 250. doi:http://dx.doi.org/10.1016/j.ijnurstu.2016.04.018

Van Tosh, L. & del Vecchio, P. (2000). *Consumer-operated self-help programs: a technical report (*DHHS Publication No. [SMA] 01-3510). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Van Vught, M. D., Kroon, H., Delespaul, P. A. E. G., & Mulder, C. L. (2012). Consumer providers in assertive community treatment programs: associations with client outcomes. *Psychiatric Services, 63*(5), 477-481. doi:10.1176/appi.ps.201000549

Verhaeghe, M. & Bracke, P. (2012) Associative stigma among mental health professionals: implications for professional and service user well-being. *Journal of health and social behavior, 53*(1). 17 – 32. doi: 10.1177/0022146512439453

Wang, P. S., Demler, O., & Kessler, R. C. (2002). Adequacy of treatment for serious mental illness in the United States. *American Journal of Public Health, 92*(1), 92- 98. doi:10.2105/AJPH.92.1.92

Warner, R. (2004). *Recovery from schizophrenia: psychiatry and political economy* (3rd ed.). New York, NY: Brunner-Routledge.

Wexler, B., Davidson, L., Styron, T., & Strauss, K. (2007). Severe and persistent mental illness. In S. C. Jacobs & E. E. H. Griffith (Eds.), *40 years of academic public psychiatry* (pp. 1-20). Hoboken, NJ: Wiley.

Wurtzburg, S. & Rocchio, C. (2014). *Culture and mental illness.* In W. C. Cockerham, R.

Dingham, & S. Quah (Eds.), Wiley- Blackwell Encyclopedia of Health, Illness, Behavior, and Society. Oxford, UK: Wiley-Blackwell.

Wyatt, R. C. & Livson, N. (1994). The not so great divide? Psychologists and psychiatrists takes stands on the medical and psychosocial models of mental illness. *Professional Psychology, 25*(2), 120-131.

Zinman, S. (1982). A patient-run residence. *Psychiatric Rehabilitation Journal, 6,* 3 – 11.

Zinman, S., Budd, S. & Bluebird, G. (2009, December 17). The history of the mental health consumer movement [Webinar]. *In SAMHSA's Resource Center to Promote Acceptance, Dignity, and Social Inclusion Associated with Mental Health Center Webinar series.* Retrieved from http://www.promoteacceptance.samhsa.gov/teleconferences/archive/training/teleconference12172009.aspx

Appendix A: President's New Freedom Commission on Mental Health

Goal 1: Americans Understand that Mental Health Is Essential to Overall Health.

- Recommendation 1.1: Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
- Recommendation 1.2: Address mental health with the same urgency as physical health.

Goal 2: Mental Health Care is Consumer and Family Driven

- Recommendation 2.1: Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- Recommendation 2.2: Involve consumers and families fully in orienting the mental health system toward recovery.
- Recommendation 2.3: Align relevant Federal programs to improve access and accountability for mental health services.
- Recommendation 2.4: Create a Comprehensive State Mental Health Plan.
- Recommendation 2.5: Protect and enhance the rights of people with mental illnesses.

Goal 3: Disparities in Mental Health Services Are Eliminated.

- Recommendation 3.1: Improve access to quality care that is culturally competent.
- Recommendation 3.2: Improve access to quality care in rural and geographically remote areas.

Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.

- Recommendation 4.1: Promote the mental health of young children.
- Recommendation 4.2: Improve and expand school mental health programs.
- Recommendation 4.3: Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- Recommendation 4.4: Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Goal 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated.

- Recommendation 5.1: Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.
- Recommendation 5.2: Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- Recommendation 5.3: Improve and expand the workforce providing evidence-based mental health services and supports.
- Recommendation 5.4: Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Goal 6: Technology Is Used to Access Mental Health Care and Information.

- Recommendation 6.1: Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
- Recommendation 6.2: Develop and implement integrated electronic health record and personal health information system.

Appendix B: Key Terms

Mental health consumer. The term mental health consumer is used to describe people who have or are currently receiving mental health services (Delaney, 2010; Sharfstein & Dickerson, 2006). The term first appeared in health care literature in the late 1960s as part of a wider movement that was originally meant to encompass the entire field of health care, not just psychiatry (Reaume, 2002). Mental health professionals across North America promoted the term to encourage respect for service users as "active, informed citizens as opposed to passive recipients or patients" (Adame & Knudson, 2007, p. 158). Debate over use of the term persists considering the diversity of beliefs, opinions, experiences (e.g., involuntary service users), and views of persons who had or are currently receiving mental health treatment (see *Psychiatric Survivor*; Reaume, 2002).

Peer support. Peer support is defined as social, emotional, informational, instrumental and affiliational support that is mutually offered, shared, or provided among people with similar conditions or life experiences (Salzer et al., 2002; Solomon, 2004; SAMHSA, 2009). "The premise of peer support is that individuals who have shared common experiences can provide better support and safer environments than others who have not had a history of psychiatric treatment" (Corrigan, Mueser, Bond, Drake & Solomon, 2008, p. 359). In this study, peer support refers to adults with SMI who currently or had received mental health services and is, consequently, a peer to other mental health consumers or service users (Corrigan et al., 2008). Peer support services are organized into two program domains: self-help or mutual aid groups and peer-delivered services (Corrigan et al., 2008; Solomon, 2004).

Peer-delivered services. Peer-delivered services encompass diverse program models that share a common characteristic: services and supports are provided by peers in recovery from a

SMI to others (peers) with similar conditions in various programs and service settings (Davidson, Chinman, Sells, & Rowe, 2006; SAMHSA, 2015; Solomon, 2004). Peer-delivered services are often organized into one of three categories: peer-operated services (often referred to as consumer-operated services), peer partnerships, and peers as employees (Salzer et al., 2002; Solomon, 2004). Peer-operated services refer to autonomous, independent programs that are owned, administratively controlled and operated by mental health consumers (SAMHSA, 2011). Peer-operated services include drop-in centers, case management and crisis support services, warm lines (telephone support), and in-home supports (Frese & Myrick, 2010). All aspects of peer-operated service programs are planned, managed, and provided by peers. The nature of the relationship between consumers and peer providers are considered reciprocal in nature, even though it is assumed that peer providers are more skilled or experienced than persons served (Davidson et al., 2006). Peer providers and service recipients are both believed to mutually benefit from interactions as their relationship is characterized by the norm of reciprocity where both give and receive. Peer-partnership services are similar to consumer-operated service programs; yet, control of the program is shared with non-consumers (Salzer et al., 2002). Peer employees (e.g., peer specialists) are paid staff in traditional mental health service settings that employ peers and non-peers. Corrigan et al (2008) explained, the amount of control is similar to nonpeer employees – administrative and decision-making power is contingent on the position the peer occupies within the organization. The focus of this study is on peer employees, most often referred to as peer specialists.

Peer specialist. Peer specialists, also referenced throughout the literature as consumer or peer providers, are employees in traditional (non-peer) mental health service settings who self-identify and publicly acknowledge themselves as current or former mental health consumers in

recovery from SMI that provide services to other peers (Chinman et al., 2014; Daniels et al., 2012; Solomon, 2004). Unlike consumer professionals (i.e., adults with SMI who are also mental health professionals; Frese & Davis, 1997), peer specialists are specifically hired into designated peer positions.

Psychiatric survivor. The term psychiatric survivor refers to current or former recipients of behavioral health services who endured hardship and/or iatrogenic trauma at the hands of their provider or treatment team (Sharfstein & Dickerson, 2006). Psychiatric survivors often reject the notion of identifying themselves as mental health consumers or service users (Reaume, 2002).

Self-help or mutual aid groups. Self-help and mutual aid groups refer to voluntary, naturally-occurring groups consisting of persons with shared life experiences providing mutual support to one another in hopes of improving their health, wellbeing, or condition (Daniels, et al., 2012). Often, the terms self-help and mutual aid are used interchangeably, yet self-help interventions have individualistic connotations whereas mutual aid groups are social. Mutual aid groups are also characterized by their emphasis on mutuality, reciprocity (Davidson, Chinman, Sells & Rowe, 2006), voluntary association, and use and valuation of experiential knowledge (Munn-Giddings & McVicar, 2006).

Serious mental illness (SMI). The term SMI is defined by section 1912(c) of the Public Health Services Act, as amended by Public Law 102-321 as "persons ages 18 years of age and older who currently or at any time during the past year have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-III-R that has resulted in functional impairment which substantially interferes with or limits one or more major life activities" (Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act of 1992). The federal definition excludes

neurodevelopmental and substance-related disorders, unless they co-occur with another diagnosable mental disorder listed in the Diagnostic and Statistical Manual for Mental Disorders (American Psychiatric Association, 2013). The disorders themselves, as described in the law, are episodic, recurrent, and persistent. The nature, extent, and severity of these disorders vary; however, almost all are characterized as significantly interfering with functioning in family, community and work life. The federal definition is broad and inclusive, whereas State definitions of SMI, including Hawaii's, may focus on narrow band of specific diagnoses (Goldman & Grob, 2006; Hawaii Administrative Rules, Mental Health and Substance Abuse Systems, 11-175-02)

Appendix C: Recruitment Flier

Dear Hawaii Certified Peer Specialist,

My name is Christopher Rocchio. I am a graduate student at the University of Hawaii. I am conducting a study to better understand the perspectives and experiences of Hawaii Certified Peer Specialists. This study has been approved by the University's Committee on Human Studies.

I am currently interviewing Hawaii Certified Peer Specialists and am writing to see whether you would be interested in participating. This study is open to Hawaii Certified Peer Specialists who have completed their internship or have worked in Hawaii in a mental health service setting.

If you choose to participate, you will be asked questions about your experiences and perspectives of the program. You will also be asked questions about your own recovery.

Interviews are approximately 1 – 2 hours in length. If you agree to participate, we will meet in a safe, secure place where you can talk freely about your experiences and perspectives without being heard.

All information will be kept confidential. All interviews are recorded for later transcription. Once transcribed, all recordings will be destroyed. My instructor, Dr. Paula Morelli and I are the only two people who will have access to recordings and original transcriptions.

I have attached a copy of the informed consent form for your review.

If you choose to participate, you will receive a $20 gift card for your participation.

If you have questions about this study, please contact me at (808) XXX – XXXX. If you are interested in participating in this study, please contact me at (808) XXX – XXXX.

Please contact me by phone. Please refrain from contacting me by email. This will protect your confidentiality.

Thanks for your consideration,
Chris

Appendix D: Informed Consent Form

Informed Consent Form
Mental Health Service Users as Peer Providers

A. Purpose and Background

The purpose of this study is to understand the experiences of Hawaii's peer specialists. You have been asked to participate in this study because you are a certified peer specialist. You are being asked for consent to participate in the study. You are not being asked to receive mental health treatment.

B. Description of Participation

If you choose to participate, you will be asked a series of open questions about your experiences as a peer specialist. If you choose to participate, you will be asked open questions about your own recovery. Questions may include:

- How did you learn about the peer specialist training?
- What was the training like?
- How has the program impacted your life?
- What was your life like before attending the training and receiving certification?

Interviews will be conducted in a place that is convenient for you. Interviews will take place in a private space. Interviews will take approximately 1 to 2 hours to complete. Approximately 20 peer specialists may participate in this study. Interviews will be recorded for later transcription. Recordings will be destroyed after they are transcribed. All recordings and transcriptions will be secured in a locked filing cabinet. Only the investigators can open this cabinet.

C. Risks and Benefits

It is believed that there is little to no risk from participating in this study. However, there may be a small risk that interview questions may upset you. If this happens, the interviewer will make sure that you get help for your concerns.

The interviewer is a licensed clinical social worker. Upon request, the interviewer may provide information regarding various mental health resources in the community, including a copy of Mental Health America of Hawaii's Human Services Directory for the State of Hawaii (Mental Health America of Hawaii's Human Services Directory is available online at http://mentalhealthhawaii.org/img/findingHelpPhoneList.pdf).

In addition, participants may contact Aloha United Way's 211 program by calling 211 from any phone for guidance with identifying mental health supports. You may not personally benefit from participating in the study. It is believed that results from this study may identify other benefits to peer specialists beyond employment.

D. Compensation

If you agree to participate, you will receive a $20 Visa gift card that you may use wherever Visa is accepted.

E. Protection of Information
All information collected from you is confidential. None of the information will include your name or other identifying information. Any papers with your name on them will be kept in a locked filing cabinet. Your name will never be disclosed. Information collected from you will be grouped together with information collected from others. Findings will be summarized to prevent others from identifying you.

The investigators will keep information about you as private as possible, except if harm to you, harm to others, or child abuse becomes a concern. The investigator is required by State law to report these concerns.

The University of Hawaii's Committee on Human Studies has the right to look at information that is collected.

F. Rights Regarding Decision to Participate
Participation in this study is your choice. You are free and encouraged to ask questions at any time. You are free to quit at anytime. You have the right to not answer any questions asked in the interview. Your refusal to answer questions or participate in this study will not affect your services you receive now or in the future.

G. Contact Information
If you have any questions about this study, please call the Principal Investigator. Her name is Dr. Paula Morelli. You can contact her at (808) XXX - XXXX. If you have any questions regarding your rights as a research participant, please contact the University of Hawaii's Committee on Human Studies at (808) 956 – 5007. (10.0)

H. Voluntary Consent
I read this form or it has been read to me. I understand what it says. My questions have been answered. A copy of this consent form was given to me. By signing my name below, I freely agree to participate in this study.

*Paper Copy

___ I allow the researcher to audiotape today's interview _____ (participant's initials)
___ I do not want my interview to be recorded.

Name: _____Signature_____

Date: _____

___ PARTICIPANT COPY
___ PROJECT COPY

*Electronic Copy

Please print and save a copy of this informed consent form for your records.

1. I have read, reviewed, and understand this form in its entirety.
__ Yes, I have read, reviewed and understand this form in its entirety.
__ No, I have not read, reviewed, and understand this form in its entirety.

2. Please type your first and last name here along with the date as your electronic signature. Example: Jane Doe 7/25/2012.

3. The researchers may audio record today's interview.
__ Yes, I am allowing the researchers to audio record the interview.
__ No, I am not allowing the researchers to audio record the interview

Appendix E: Screening Questions for Informed Consent

1. True or False: Participation in this study is voluntary.
2. True or False: I may ask questions at any time before, during, and after the interview.
3. True or False: All answers to questions asked in this interview will be kept confidential, except if harm to myself, harm to other, or child or adult abuse is reported.
4. True or False: I may quit the interview at anytime.
5. True or False: I don't have to answer questions asked in this interview.
6. True or False: I understand that recordings will be transcribed and later destroyed.

Appendix F: Interview Guide

1. When did you take the HCPS training?
2. How did you learn about the peer specialist training?
3. What influenced you to consider becoming a peer specialist?
4. What were your reasons for applying for and completing the program?
5. What was your life like before attending the training and receiving certification?
6. What was the training like?
7. What do you remember most about the training?
8. How is your life now after the training?
9. What were your expectations following graduation from the program?
10. In what ways has being a peer specialist changed you?
11. How has the program impacted your life?
12. What suggestions do you have for others interested in the program?
13. Were there any aspects of the training you had hoped to be different?
14. Any other comments that you would like to share regarding the peer specialist program?